VS. ATSME 5M 2/57

Norman T. Baker

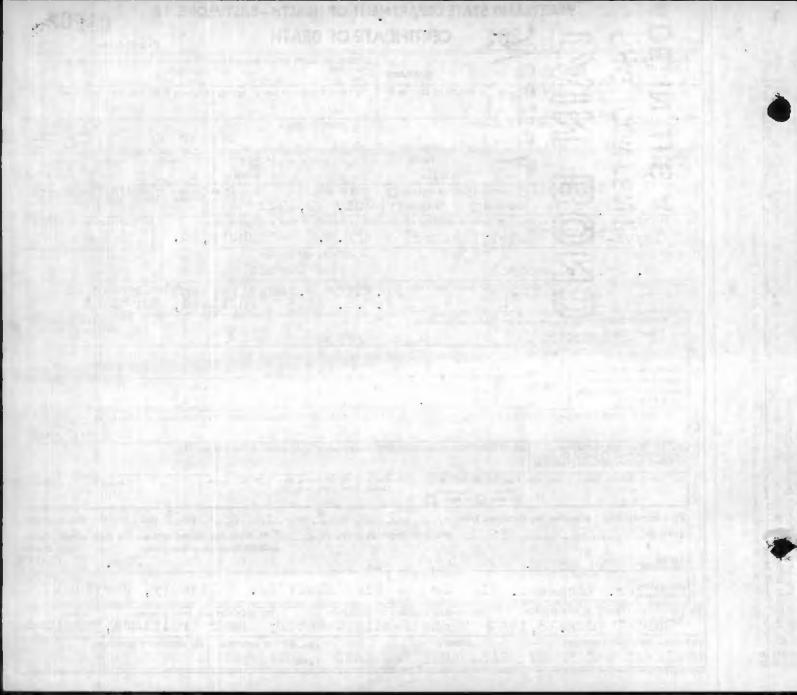
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10	TO FUNERAL DIRECT: After this certificate has been signed by the attending physician and completely filled in by the half director, page 3 should be defacted for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, crematian, or removal, and in any event within 72-hours after death.
VS 15A	A 10/57

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may be retained by the haspital or offending physician	TO FUNERAL DIREC .: After this certificate has been signed by the attending physician and completely filled in by the	page 3 should be defached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shound be file	the registrar prior to buriel, cremation, or removal, and in any event within 72-hours after death.	
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N	110	1/5	7	

ikbi	CERTIFICA	ALE OF DEA	AIH	Reg. D	ist, No.
a. COUNTY	MARYLAND	2. USUAL RESIDENCE o. STATE	(E) Where deceased lives	b. COUNTY	nce before admission)
RURAL and give nearest town)	LENGTH OF STAY IN 16	c. CITY OR TOW	N (If outside corporate I	imits, write RURAL and	give nearest town)
d. NAME OF HOSPITAL (If not/in hospital, give street odd OR INSTITUTION	pith	d. STREET ADDR	ESS	iter St	e. 15 RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print) Dorothy	MARIE MARIE	Bank	4. DATE OF DEATH	Month in wary	Day Yeor 15 1959
Franche WIbite WIDOWED!	DIVORCED		1921 3	st birthdoy) Months	Days Hours Min.
on. USUAL OCCUPATION (Give kind of work dane 10b. KIN during most of working life, even if religed) Employee-Shirt Factory	id of Business or Indus (Packer)		(State or foreign country Salisbury		TIZEN OF WHAT COUNTRY?
3. FATHER'S NAME		14. MOTHER'S MAI	DEN NAME		
G. Walter Hancock		Mae I	ennis		
5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SO( Yes, no. or unknown). [31 yes, give wor or dates of service)	LIL	Arton H. O.B. #11	Banks(Hus 5 Fruitl	band) Ce	nter St yland
18. CAUSE OF DEATH [Enter only one cause per line for	or (a), (b), and (c).	11 1	1.1		INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	nan tere	Heart	Heider	C.	ONSET AND DEATH
410× DUE TO 00	1 1-11	1 .0		1.7	
Canditions, if any, which ) (b) the	who die 168	art hes	east, w	the	
gave rise to immediate cause (a), stating the under-	Estral, Stews	our and	Mitalle	ner Heriena	
lying cause lost. (c) (c)	in Stenou	auf a	or les Dru	ulthouse	,1
Part II. OTHER SIGNIFICANT CONDITIONS CON	ITRIBUTING TO DEATH BUT	NOT RELATED TO THE	TERMINAL DISEASE CON	ID TION GIVEN IN PA	PERFORMED?
200. ACCIDENT WAS UNDERLYING   206. DESCRIE OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	BE HOW INJURY OCCURRED	). (Enter nature of inju	ry in Part I or Part II of	item 18.)	
20c. TIME OF INJURY Manth, Day, Year 20d. INJU Hour a. m, p. m. 19 at wark	_ Nat while fac	CE OF INJURY (Home tary, street, office bld	t, farm, 20f. (City or ta g., etc.)	wn)	(Stote)
21. I certify that I attended the deceased	fram. 1 13		1/15	1957 that I	last saw the deceased
alive on 1/15 , 1950	7_, and that death	occurred at 5	4) / /		the date stated above.
41 0	117/0		ADDRESS (Street,	city or town, state)	DATE SIGNED
SIGNATURE TOULOS C	· Hell In	w.D		J	an. /5 /1959
PHYSICIAN'S Dr. Thomas C. Hi	11 Jr 1	Pine Bluf	f Rd. Sal	isbury,	Maryland
REMOVAL (Specify)  Burial Jan. 18, 1959	Banks Fam:	crematory ily Cemet		(City, fown, or county) Fruitla	nd, Maryland
3. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		REC'D BY REGISTRAR	24b. REGISTRAR'S SI	
OLLOWAY & COMPANY SAL	ISBURY MAR	YLAND DAT	EJAN 1 9 '59	Comment of	, result



# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1262 CERTIFICATE OF DEATH 01263

	, , , , , , , , , , , , , , , , , , , ,		•	Reg. Dist. No.	
1. PLACE OF DEATH .  o. COUNTY () CEINCE	MARYLAND	2. USUAL RESIDENCE (W	\$7COU	titution: Residence before adm INTY CCL TMCC)	nission)
b. CITY OR TOWN (If outside corporate limits, write RURAX and give nearest lown)	c. LENGTH OF STAY IN 16		outside corporate limits, wri	ite RURAL and give represt to	own)
d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION	A VIII	d. STREET ADDRESS		ON	RESIDENCE N A FARM? NO Z
3. NAME OF DECEASED (Type or print)	Middle	James	4. DATE OF DEATH /	Month Day	Yeor 19 59
5. SEX 6. COLOR OR RACE 7. MARRI	D DIVORCED	B. DATE OF BIRTH	9. AGE (In ye last birthdi	eors IF UNDER I YEAR I YEA	
10a. USUAL OCCUPATION (Give kind of work done 10b. dwying most of working life, even if retired)	KIND OF BUSINESS OR IND	m.c		12. CITIZEN OF WH	AT COUNTRY
13. FATHER'S NAME		14. MOTHER'S MAIDEN	NAME S		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [16.   Yes. no or unknown]   If yes, give wor or dates of service)		Bedonie-	Parken	Address	
1B. CAUSE OF DEATH [Enter only one couse per lin PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	e for (o), (b), and (c)	rollor	1010:	INTERVAL ONSET AL	BETWEEN ND DEATH
334× DUE TO		1 arte	iscala	1	
Conditions, if ony, which gove rise to immediate couse (a), storing the <u>under-lying couse lost.</u> (b)  (b)  (b)  (c)	m said		COS CLUBA		
PART II. OTHER SIGNIFICANT CONDITIONS C  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH UIF EITHER, NOTIFY MEDICAL EXAMINER;	ONTRIBUTING TO DEATH BI	JT NOT RELATED TO THE TERM	INAL DISEASE CONDITION	GIVEN IN PART 1(0) 19. WA PER YES	REORMED?
	RIBE HOW INJURY OCCUR	RED. (Enter nature of injury in	Port I or Part II of item 18.	.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., 19 Utile of work	Not while	PLACE OF INJURY (Home, fore factory, street, office bldg., etc.	n, 20f. (City or town)	(County)	(State)
21. I certify that I offended the decease	$\sim$	1958, 10	1500 17	Ghat Plost sow th	
olive on 2 19	and that deal	th occurred of	ADDRESS (Street, gily of to	nd on the date sto	DATE SIGNE
SIGNATURE SIGNATURE	7	M.D. 65 24	Lima	64	ans
PHYSICIAN'S FA LYY	el Mi	). Salu	turns	mo	
226. BURIAL, CREMATION, 226. DATE THEREOF	22c. NAME OF CEMETERY	OR CREMATORY	22d. LOCATION IT ITY.	or county) (S	lote)
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	0.00		REGISTRAR'S SIGNATURE	
1 - h du 1 64 11/6, 021		DATE IN	N 1 5 50	Cathur & Alana	

TO HOSPITAL OR ATENDING PHYSICIAN: The fow requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attending physician.

TO FUNERAL DIRECT: After this certificate has been signed by the attending physician and completely filled in by the page 3 should be deadched for use as the burial-transit permit. Then please remove carbon pagers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

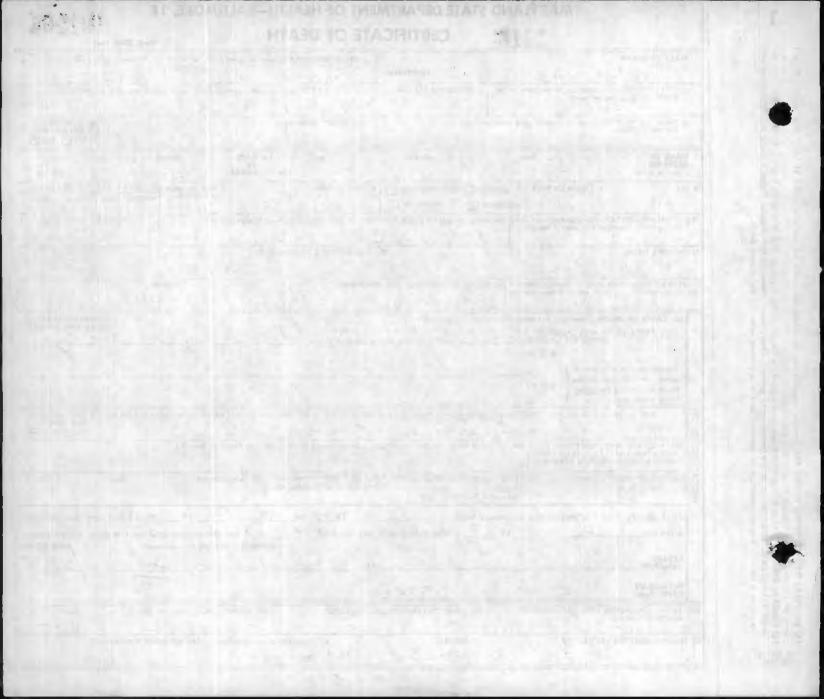
01264 7217 CEPTIFICATE OF DEATH

	7270	CERTIFICA	ALE OF BEATTI	Reg. Dis	t. No.
1. PLACE OF DEATH  o. COUNTY  1 C U M	100	MARYLAND	2. USUAL RESIDENCE (Where de	b. COUNTY	ce before admission)
b. CITY OR TOWN (If outside RURAL and give nearest tow	n)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If oulside	corporate limits, write RURAL and a	ive nearest town)
d. NAME OF HOSPITAL (If no	in hospital, give street a	ddress)	d. STREET ADDRESS	-11	e. IS RESIDENCE ON A FARM? YES NO N
3. NAME OF DECEASED (Type or print)	HENRY	DONAL D		DEATH Month	Day Year
5. SEX 6. COL	OR OR RACE 7. MARRI		B. DATE OF BIRTH MBY 28, 188	South South days	YEAR IF UNDER 24 HRS. Days Hours Min.
PETIRED	kind of work done 10b. t even if retired)	ROKERAGE (		eign country) P1+, 12. CITI	U, S ))-
13 FATHER'S NAME	ECHTEL		CLARA	SHYLOR.	
15. WAS DECEASED EVER IN U. S (Yes, no or unknown) (If yes, give	ARMED FORCES? 16. S		Mes. SARA	SUTTON OCE	AN CITY
		for (a), (b), and (c).] Subar	a chroid Har	nowhage	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, whice gove rise to immediate course (a), stating the underlying course lost.	e ( DUE TO				
PART II. OTHER SIGN  PART II. OTHER SIGN  20a. ACCIDENT WAS UNDER  OR CONTRIBUTING  CAUS  URF EITHER, NOTIFY MEDICAL		ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL OF	DISEASE CONDITION GIVEN IN PART	1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	ELYING TO 206. ÓESC E OF DEATH EXAMINER)	RIBE HOW INJURY OCCURRE	D. (Enter noture of injury in Part 1	or Parl II of item 18.)	
20c. TIME OF INJURY Month Hour o. m. p. m.	n, Doy, Year 20d. IN While 19 of work	Not while for	ACE OF INJURY (Home, form, 20) ctory, street, office bldg., etc.)	(Cily or lown) (C	ounly) (State)
21. I certify that I atleative an	ended the decease	d fram. 1/2- 2, and that death		fram the causes and on the test (Street, city or town, stote)	ast saw the decease te date stated above
PHYSICIAN'S NAME (Type)	E.M. 1	ARMORE		/	, ,
BURIBL J	AN 3 1959	LAURELD		READING	(Slote)
23. FUNERAL DIRECTOR'S SIGNA	Bubace	Berlin	md 240. REC'D BY	REGISTRAR 246. REGISTRAR'S SIG 5 159 Curing S.	73

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the force of spage 3 should be defacted for use as the burial-transit permit. Then please remove carbor-pagers. Pages 1 and 2 should be filled with the registrar prior to burial, crematian, ar remaval, and in any event within 72 haurs after death.

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death: Roge 4

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01265

1263 **CERTIFICATE OF DEATH** 

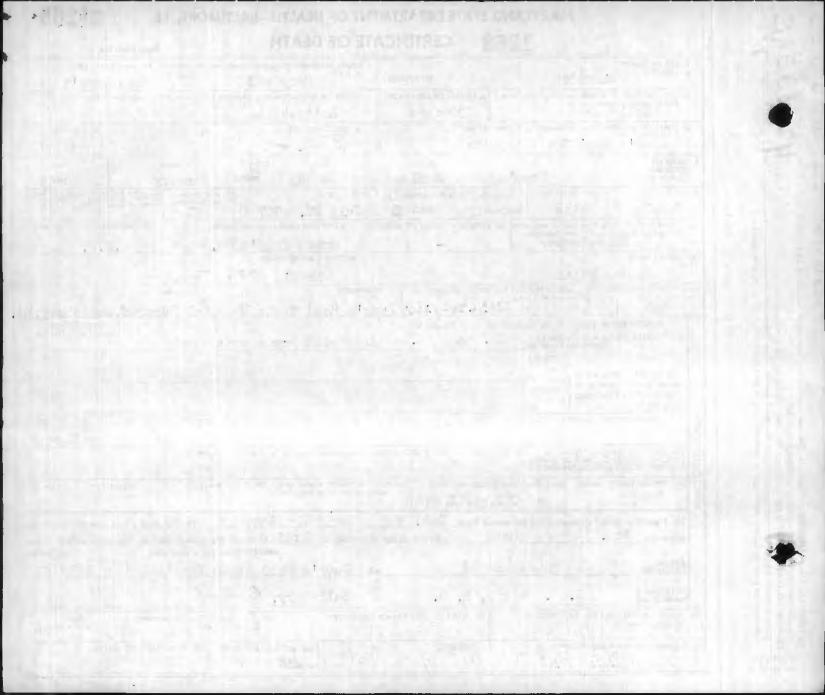
Reg. Dist. No.

	1. PLACE OF DEATH  o. COUNTY  Wicomico	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Ougen Anne's					
	b. CITY OR TOWN (If outside corporate fimits, write RURAL and give neprest town) SELISBUTY	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corp	AL and give nearest fawn)			
1	d. NAME OF HOSPITAL (If not in hospital, give street or INSTITUTION Deer's Head State Hospital)	address)	d STREET ADDRESS R7A#2		e. IS RESIDENCE ON A FARM? YES NO		
	3. NAME OF First DECEASED (Type or print) Dorothy	Middle Ruelma	Lost 4. DATE OF DEATS	Month	Day Year		
	5. SEX 6. COLOR OR RACE 7. MARI		B. DATE OF BIRTH	o constant y	12 1959 UNDER I YEAR IF UNDER 24 HRS.		
	Female White wipowi	DIVORCED 🔀	July 27, 1907	lost birthday) Me	onths Days Hours Min.		
	100. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired) HOUSEKEEPET	KIND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (Stole or foreign Queen Anne s		12. CITIZEN OF WHAT COUNTRY		
1	13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		3,0,11,		
1	Marion Potts		Mattie 57	auton			
/	(Yes, no. or unknown)   {II yes, give wor or dates of service)		er's Head State Ho	Address	ords Solishum M		
1	Canditions, if any, which gove rise to immediate cause (a), stating the underly DUE TO lying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS C	ontributing to death but		SE CONDITION GIVEN I	INTERVAL BETWEEN ONSET AND DEATH  IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO 1		
	20c. TIME OF INJURY Month, Day, Year 20d. It White	NJURY OCCURRED 20e. PU	CE OF INJURY (Home, farm, 20f. (Citary, street, affice bldg., etc.)		(County) (Stole)		
	21. I certify that I attended the decease ative an Jan. 12 195.  ACTUAL SIGNATURE L. V. Maldv.  PHYSICIAN'S L. V. Maldv.  220. BURIAL, CREMATION, 12%. DATE THEREOF	2, and that death	occurred of 1:45AM, fro ADDRESS (S A.D. Deer's Head St Salisbury, Mar	12 , 19 59,th m the causes and direct, city or lown, state ate Hospita yland TION (City, town, or co	DATE SIGNED  1/12/59		
	23. FUNERAL DIRECTOR'S SIGNATURE WEAR-EL BRECOM, BELLE Ber	Chesterfield ADDRESS, Grielserelle	0	TRAR 246. REGISTRA	Mary Lancos (STORATURE S. Knows		

TO MOSPITAL OR AZZENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after may be retained by the haspital or attending physician.

SEUNERAL DIRECTORY After this certificate has been signed by the attending physician and campletely filled in by the page 3 should be defacted far use as the burial-transit permit. Then please remove carbon papers. Fages 1 and 2 shouther registrar prior to burial, crematian, ar removal, and in any event within 72 hages offer death. may be retained by

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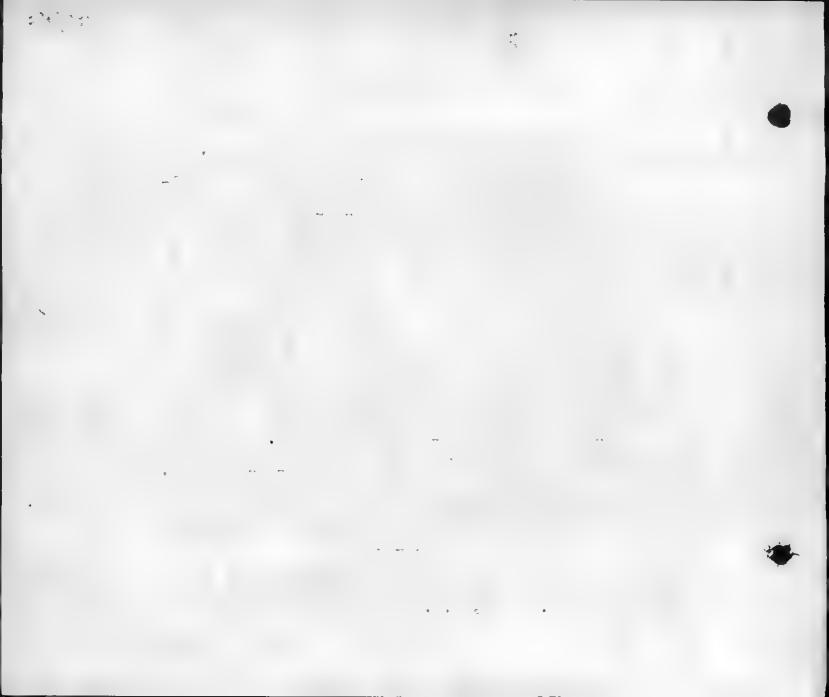
FUNER

VS A15 (4) 15M 9/55

depth.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH OR STATE Reg. Dist. No. HEALTH DEPT PLACE OF DEATH 2 USUAL RESIDENCE (Where decreased lived. If institution, Residence before admission) a. COUNTY files. Heolth, O. STATE b. COUNTY MARYLAND Wicomico Virginia b CITY OR TOWN (If outside corps are knots, write BURAL C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest lown) Salisbury Chincoteague d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS . IS RE DENICE ON A FARM? Peninsula General Hospital YES NO retained 125 Mumford St. itote leath. 3. NAME OF Middle DATE Month Yeor DECEASED (Type or print) DEATH Ma vme Burton 19 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 1 B DATE OF BIRTH 9 AGE (In years 5. SEX IF UNDER TYEAR IF UNDER 24 HRS fort birthday) Months Doys WIDOWED PAK DIVORCED [ 3-16-90 100. USUAL OCCUPATION (G've kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 12 CITIZEN OF WHAT COUNTRY? during most of working life, even I retired) run Home Sive Pages 1 farm PM3. File pages 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 24 ho M6 SOCIAL SECURITY NO 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? m 18. G ō 18. CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c) INTERNAL BETWEEN along ONSET AND DEATH Acute congestive heart failure hour IMMEDIATE CAUSE (a) Office DUE TO Extensive hemorrhage left buttock 12 hours Conditions, If any, which gove rise to immediate cause **DUE TO** (o), stating the underlying couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Arterio-sclerotic cardio-vascular disease. YES NO A 200 bix per for any production in a new of the man of the reh -1958 200. EXTERNAL CAUSE WAS X PRIMARY OF CONTRIBUTING OF CAUSE OF DEATH. Hip prothesis inserted 1-14-59 by Dr. Frank 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 120f. [City or town) 20c TIME OF INJURY Month, Doy, Year (County) (Stole) factory, street, office bldg , etc.) Marche 58 of work of work of Chincoteague Va. 21. I certify that I took charge of the remains described above, held on Autopsy . Inspection F. Inquiry opinion death resulted from. Natural causes . Accident . Suicide . Homicide . Undetermined monner DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE should be ASSISTANT MEDICAL EXAMINER NAME (Type) DEPUTY MEDICAL EXAMINER L. Royer, M.D. 224. BURIA. CREMAT ON 226. DATE THEREOF 27c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stote) em. 23. FUNERAL DIRECTOR'S SIGNATURE 24a REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE VS. A15ME 5M 2/57



VS A1S (4) 15M 10/S7

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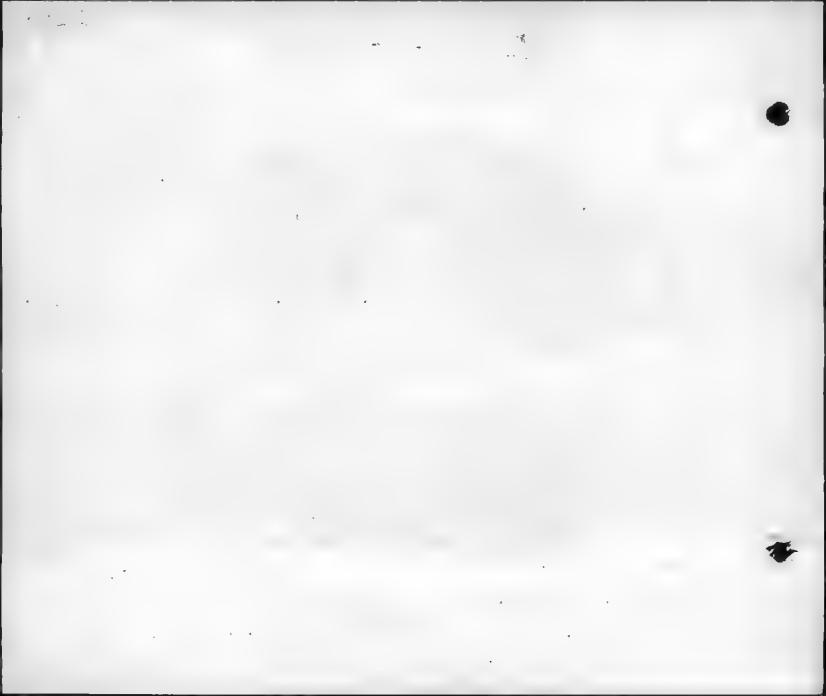
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1265

**CERTIFICATE OF DEATH** 

01268

Reg. Dist. No.

1. PLACE OF DEATH W1COMic	0	MARYLAN	2. USUAL RES	DENCE (Where dece Maryland	ased lived	. If institution b. COUNTY		before odmissi OMICO	on)
b. CITY OR TOWN (If outside carpora RURAL and give Aparest John) SELISDU	te limits, write c. LEI	IGTH OF STAY IN 1	c. CITY OR	TOWN (If outside co	rporate lie	riti, write RU	RAL and gives	e nearest tawn	
or institution pen Gen	Hospital	1	d. STREET	ADDRESS In Villa	ge			e IS RESI ON A YES	
3. NAME OF DECEASED (Type or print)	First ORA	ODELL Middle	CATL			JAN.			, 59
S SEX 6 COLOR OR 1	WIDOWED	SI BILLER CED	April	5,1891	los	E (In years birthday) yrs	Months 79	TEAR IF UNDER	M n
10a USUAL OCCUPATION (Give kind of during most of working life, even if r Laborer	work dane 10b KIND ( etired)	OF BUSINESS OR IN		ACE (State or foreign)	n country)		U U	S A	COUNTRY
13. FATHER'S NAME			14. MOTHER'S	MAIDEN NAME					
Spence Catlin			Cat	herine M	cGra	th			
15 WAS DECEASED EVER IN U. S. ARMEI (Yes, no or unknown) (If yes, give wor or do	D FORCES? 16. SOCIAL	SECURITY NO.		ie R.Dyk			") Fru	itland	,Md.
Canditions, if any, which	BY:	a), (b), and (c).]	hoge !	Lo Co	le	tis		INTERVAL BET ONSET AND I	WEEN
PART 11. OTHER SIGNIFICANT  200 ACCIDENT WAS UNDERLYING IN CAUSE OF DI  OR CONTRIBUTING IN CAUSE OF DI  (IF EITHER, NOTIFY MEDICAL EXAMILE)							N IN PART 3	(g) 19. WAS A PERFOR YES	MED?
	NER)	OW INJURY OCCUR	RED. (Enter nature a	f injury in Part I ar	art II af i	tem 18.)			
20c TIME OF INJURY Month, Day Hour a. m. p. m.	, Year 20d. INJURY ( While N of wark all	ot while work	PLACE OF INJURY ( factory, street, affic	Home, form, 20f. (i bldg., etc.)	lity or tax	/n)	(Cou	inly)	(State)
21. I certify that I attended the deceased fram.  19 1, to 19 1, that I last saw the deceased olive on 19 1, and that death occurred at 1, 30 M, from the causes and on the date stated above.  ACTUAL SIGNATURE  M.D. M.D. M.D. M.D. M.D. M.D. M.D. M.D									
PHYSICIAN'S Dr. Will:		ith		cal Cent				Maryla	nd
Furial Jan.1		ion Ceme			D.#	Eden		ryland	
23. FUNERAL DIRECTOR'S SIGNATURE		DORESS		24a. REC'D BY REC	ISTRAR	24b. REGIST	RAR'S SIGNA	ATURE	
HOLLOWAY & COMPA	AWY SALI	SBURY MA	RYLAND	DAJEAN 1 9 '5	9	Constant	1 8. 40	u.4	



240 REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

ADDRESS

& Johnson Co. Salisbury, Md.

T. Baker

VS A15 (4) 15M 9/55

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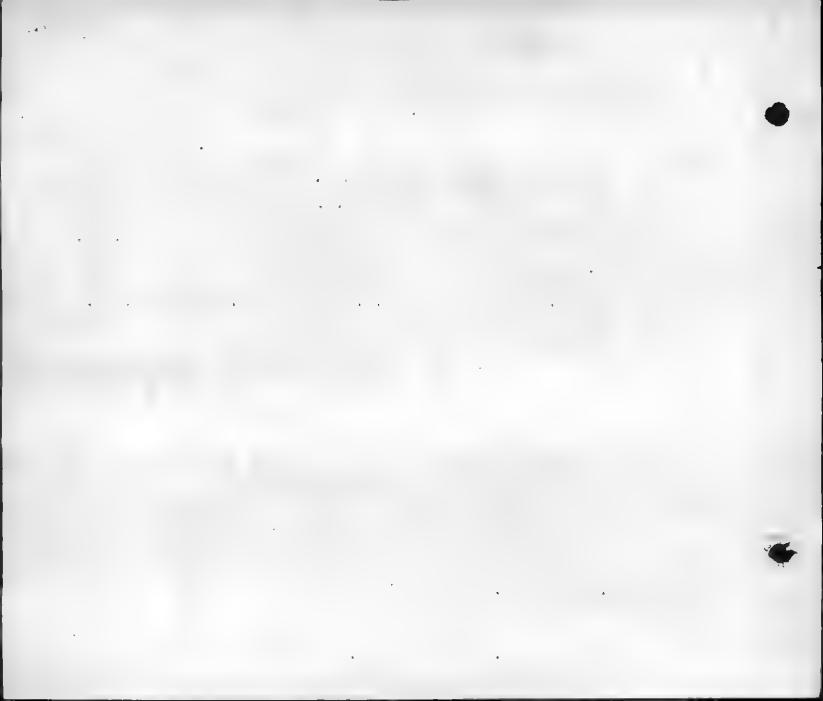
23 FUNERAL DIRECTOR'S SIGNATURE

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		740	<b>a</b>		-	12 01 01		•		Reg. Dist	No.	
	LACE OF DEATH COUNTY	orcico		MARYL	- 11	raryle	nce (we	era deceased l	b COUNTY	n Residence	before admi	ssion)
b	C TY OR TOWN (I RURAL and give no	If outside corporate timi eorest lawn)	ls, write	c LENGTH OF STAY II	ч 1Ь				te limits, write Ri	URAL ond gi	ve nearest for	wn]
	Jali shu					/: Salis	bur;	У				
d	OR INSTITUTION	At (If not in haspital, g	ive street	address)		d. STREET ADD			. 1.		ON	A FARM?
	210	O Delawar	e St	rect	II	<u> </u>	Law	are S	urcht		YES	] NOV
D	(AME OF DECEASED Type or print)	Ishman	s)	Middle	Ch	andler		4. DATE OF DEATH	Januar		Day	Yeor 19 59
5. SI	EX	6. COLOR OR RACE	7 MARR	NEVER MARRIED				9	AGE (In years		YEAR IF UN	
	rale	col.	WIDOW	DIVORCED		October		,1900	50 yrs	Months [	Days Hours	Min.
10a.	USUAL OCCUPATION	ON (Give kind of work i king life, even if retired	dane 10b	KIND OF BUSINESS OR	INDUST	RY 11. BIRTHPLAC	E (State	or foreign cou	ntry)	12. CITIZ	EN OF WHA	T COUNTRY
	saw mil	1	1			Geo	rgi	а		U	.S.A.	
13. F	ATHER'S NAME					14 MOTHER'S M	-					
	Jalos J	handler				Nacy	1-il	lor				
15. Y	WAS DECEASED EVE	R IN U. S. ARMED FOR	CES? 16	SOCIAL SECURITY NO	17 IN	ORMANT			Addr	215		
	no				Od	essa le	.Br	ide 2	10 Dela	were	Stro	et
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CERTIFICATION	PART II. OTH	HER SIGNIFICANT CON	DITIONS	ONTRIBUTING TO DEAT	TH BUT N	OT RELATED TO TH	HE TERMI	NAL DISEASE (	CONDITION GIV	EN IN PART	PERF	ORMED?
	200 ACC DENT WA OR CONTRIBUTING LIF EITHER, NOTIFY	AS UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OC	CURRED	(Enter nature of in	njury in f	Part I or Part I	l of item 18)			
MEDICAL	20c. TIME OF INJUR Hour o. m. p. m.	Y Manth, Day, Yes	While	NJURY OCCURRED 2	Oe. PLAC facto	E OF INJURY (Horry, street, office bi	me, form, ldg., etc	20f. [City o	r town)	(Cc	ounty)	(State)
	alive an	at I attended the	decease 	(mym)	death o	1958, accurred at	10 4 5 6 1/ 1/		the causes a	nd an the		
	PHYSICIAN'S NAME (Type)	-HILLY	2-1			Sala	26-6	rslj.	1- Med	/		
**0	BURIAL, CREMATIO REMOVAL (Specify)			22c. NAME OF CEMET				6 -	ON (City, lown, c	,,	(514	
23 5	DUTE AL DIRECTOR	17/13/19	59	Appress	cre			The second secon	shury		aryl	nnd
(1)	OL AS	F Still -	1	dalla last	Q1 0	/		1 6 '59		TRAR'S SIGI		
		- HALL HILL		arian y	18/13	V	_UNI	5 142	(1.1	1 0 1		

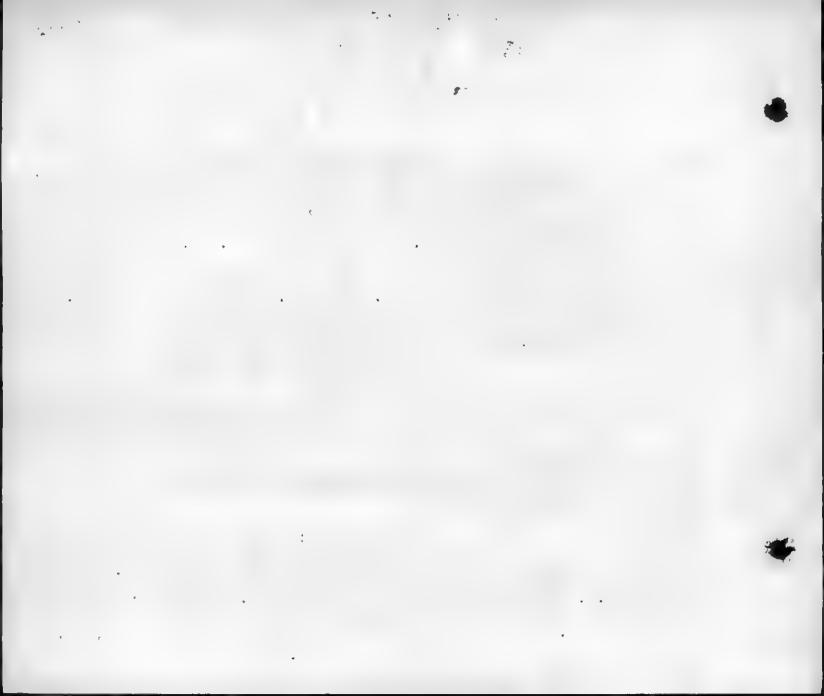
al director, TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 TO FUNERAL DIRECT. After this certificate has been signed by the ottending physician and completely filled in by the page 3 shauld be defected for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shatter registror prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A1S (4) 15M 10/57

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page was been been as a may be retained by the hospital or attending physician.  To FUNERAL DIRECT. After this certificate has been signed by the attending physician and completely filled in by the sold director and a shauld be defeated for use as the buriot-transit permit. Then please regent copies. Pages I and 2 should be filled with the registrar prior to buriot, cremation, or removal, and my event within 7 hours after death.	96		ctoil	3	
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TO HOSPITAL OR A Most be retained by the FUNERAL DIRECT 10 Page 3 should be done the registrar prior h	Ē,	,		9	ã
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V\$ A15 (4) 15M 10/57	0	=	10	a	**
	V	SN	A15	{4 )/S	7

L		7.07	LO CER	HILICA	HE OF D	EAIR			Reg. D	ist. No.		
1.	PLACE OF DEATH o. COUNTY	√icomico	MA	RYLAND		Mary]		lived If institution b COUNTY			omic	
	b. CITY OR TOWN ( RURAL and give n	(If outside corporate limits, writh nearest town) Delmar	e c. LENGTH OF ST	AY IN 16		OWN (If our Delms		ote limits, write R	URAL ond	give nea	resi lowr	)
	d NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, give stre 421 East S	•		d. STREET AL	4	East	St				FARM?
L	NAME OF DECEASED (Type or print)	CHESTEI		CIS	CLARK		4. DATE OF DEATH	JANUA		6t	- h	Yeor 1959
	Male Male		OWED 🔀 DIVOR	CED 🔲 🖁	pril l	,1883	2	9 AGE (In years last birthday) 75 yrs	Months	Doys	Hours	Min.
	during most of wor	on (Give kind of work done) if king life, even if relired) mployee (Bald									F WHAT	COUNTRY
13	FATHER'S NAME				14 MOTHER'S	MAIDEN NA	AME		*			
		David Clark			Unk							
IS {Y	WAS DECEASED EVI	ER IN U. S. ARMED FORCES? (If yes, give mor or dates of service)	16. SOCIAL SECURITY	NO. IT IN	Chêste Delmar	r H.(	Clark rylan	(Son)#2	E E	ast	St.	
	PART 1. DE/		r line for (o), (b), and ante Constanting	ones fruit	This .	mbr Ck.	is rdis	vase	rler		RVAL BE ET AND	
	gove rise to l couse (o), stating lying couse lost.		hreas							4		
CATION		HER SIGNIFICANT CONDITION							EN IN PAR	IT 1(o) 11		RMED?
L CERTIF	(IF EITHER, NOTIFY	MEDICAL EXAMINER)	DESCRIBE HOW INJURY	OCCURRED	. (Enter noture of	injury in Po	ort I or Port	II of item 18.)				
MEDICAL	Hour o.m.	Wh	f. INJURY OCCURRED ile Not white work of work		CE OF INJURY (Fory, street, office		20f. (City	or town)	(	County)		(Stole)
	21 Leading th	hat I oftended the dece	need from 2	v 7	1965	in 2	en L	19.6	9	1 .	41	1
	olive on	M. S. 19				2:001	M, from	the causes a	nd an t	he dat	e state	ed above
	SIGNATURE	r.S.Howard I	Lynch	٨٨	Delaw	are !	Ave.	Delmar.	Jan Dei	laws	re	/195
22		ON, 226 DATE THEREOF										
	REMOVAL (Specify)	1 Jan. 10, 195	22c NAME OF C					Philad		nia.	ısıdı Pa	•
23.	FUNERAL DIRECTOR	'S SIGNATURE	ADDRESS			24a. REC'D	BY REGISTR	RAR 24b. REGIS	TRAR'S SI	GNATUR	E	
H	OLI WAY	& COMPANY	SALISPUR	Y MAE		DATE JAN			thung &			



15M 10/S7

Reg. Dist. No. 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission. 1507411 c. CITY OR TOWN [1] outside corporate limits, write RURAL and give neargst lower) ... e IS RESIDENCE ON A FARM? YES NO Month Day Year 19 2 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS Doys Hours 5 12 CITIZEN OF WHAT COUNTRY Address INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES [7] NO Z (County) (Stote) \_\_\_\_\_19\_9, that I lost sow the deceased .M, from the causes and on the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED 22d LOCATION (City, town, or county) (Stote) 24b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

# YSICIAN OR HOSPITAL: The law requires that the death may be retained by the hospital or attending physician.

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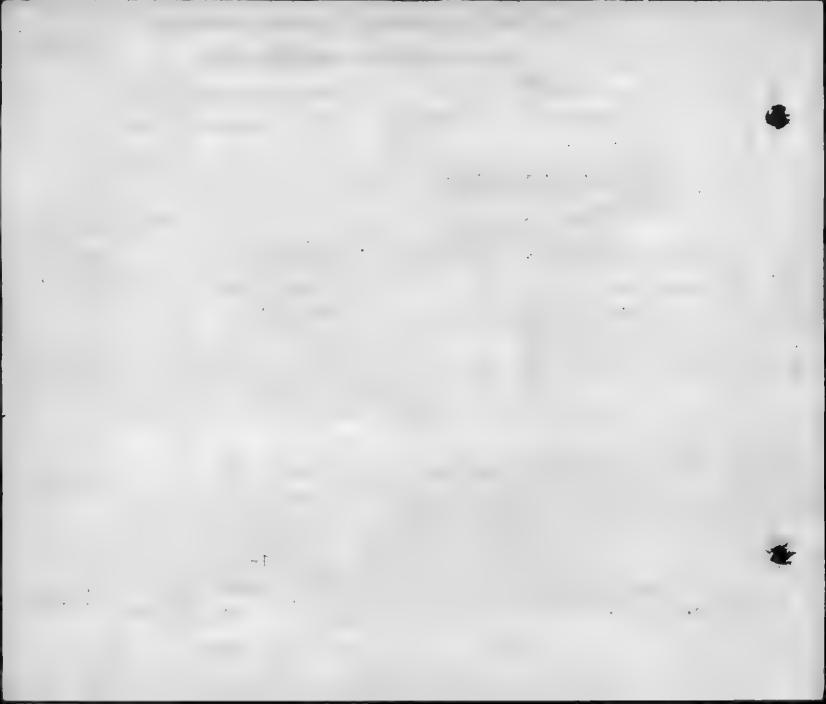
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### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

., 01273

1269	Reg. Dist. No
I. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECKASED
COUNTY WICOMICO MARYLAND	STATE Maryland COUNTY Caroline
CITY (If outside corporete limits, write RURAL LENGTH OF STAY OR and give nearest town) (jn this place)	CITY (II outside desporate limits, write RURAL and give nearest town) OR
IOWN Salisbury 17 days	TOWN / Septon
HOSPITAL OR INSTITUTION OR	STREET (Il rural give location) ADDRESS
STREET ADDRESS Springhill Sanitarium	
3. NAME OF (First) (Middle) DECEASED	(Lost) 4. DATE (Month) (Day) (Yaar)
(Type or Print) Harry S.	DEATH 1 28 19 59
RACE WIDOWED DIVORCED.	TE OF BIRTH 9. AGE lest birthday IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
Male Willte (Spacify) Wildowed Fe	b. 27, 1873   85 yrs.
done during most of working life, even if OR INDUSTRY	11. BIRTNPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
TEM 12 C	
15. WAS DECEASED EYER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.	Edga Carey
(Yes, no, or unk.) (Il Yes, give wer or dates al service)	Gail Cooper Denlow, land.
18. MEDICAL C	CERTIFICATION INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
IMMEDIATE CAUSE (A) 144 MILL TY	uskille elmay Louds
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B)	v bales
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	
(C)	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	
DISEASE OR CONDITION CAUSING DEATH.  190. DATE OF OPERATION 190. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	YES NO
216. ACCIDENT WAS UNDERLYING ☐ 216. PLACE (Homa, farm, Isclory, OR CONTRIBUTING ☐ CAUSE OF DEATH OF INJURY streat, office bldg., etc.) (IF EITHER, NOTIFY MEDICAL EXAMINER)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Dey) (Yeer) (Hour) 21s. INJURY OCCURRED White Mot white at work at work with a work work.	211. HOW DID INJURY OCCUR?
22. I hereby certify, that I attended the deceased from	, 19.7.9., to 1-28, 19.59, that I last saw the deceased
	d at 11:10 Myrom the causes and on the date stated above.
Huged R. Ysramel	ADDRESS (Street, city, town, state)  DATE SIGNET
Dr. Fred R. Gramse M.D.	402 S. Division, Salisbury 1-29-59
23. BURIAL, CREMATION, REMOVAL (SPECIFY).  ONTE THEREOF NAME OF CEMETERY 2/ 8/4/6	d- //
24. REC'D BY REGISTRAR V REGISTRAR'S SIGNATURE	1/25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
EED 9 150 No. 1	ADDRESS ADDRESS
DATE FEB 2 59	1 they moon our Venton



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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physician

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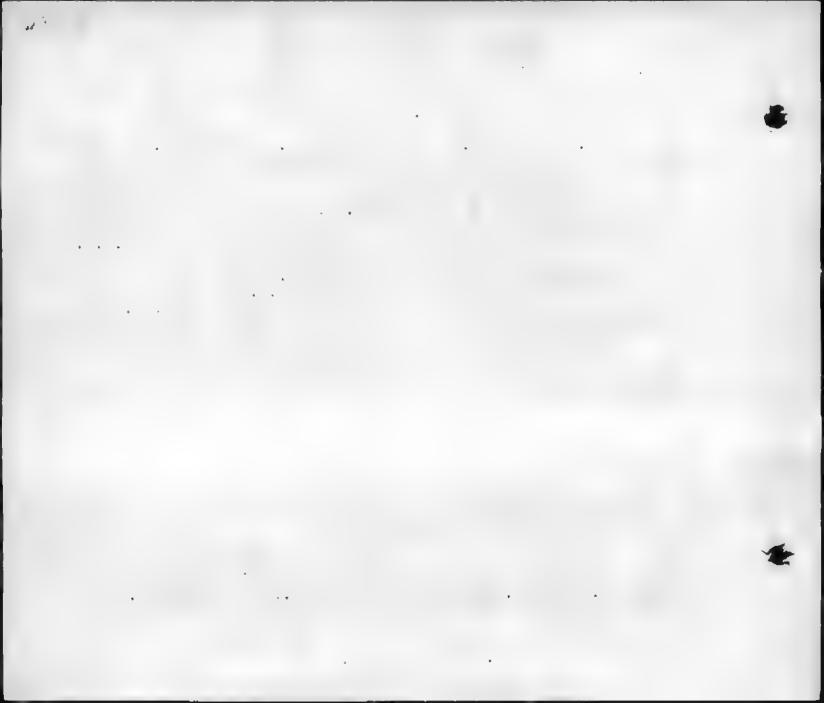
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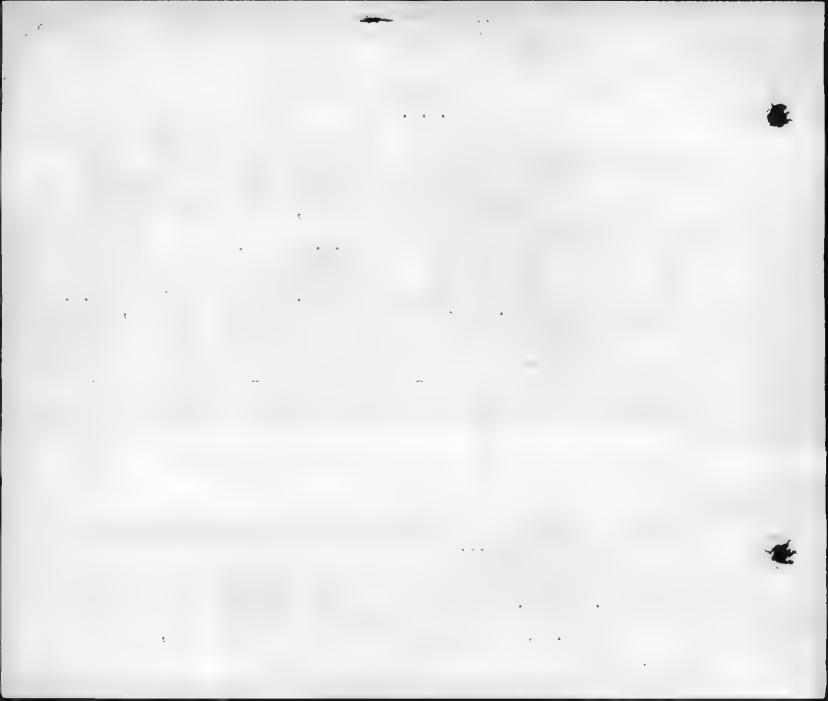
TO DEPUTY MEDICAL EXAMINER: This scritticate should be exacuted within 24 hours after death. If any delay is necess execute the certiff of writing the word "pending" is pendit in flem, 18. Give Pages 1, 2, and 3 to the funeral direct should be form at 5 to may be retained for 4 should be form per 5 may be retained for 10 FUNERAL DIRECTOR: Page 3 should be used as a buriol-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to buriol, cremation, or removal, and in any experimithin 72 hours after death.

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VS. ATSME 5M 2/57

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 01275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

		777		Keg, Uist, No.					
	LACE OF DEATH	Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived It institution: Residence before odn  • STATE Maryland & COUNTY Wicomico					
ь	ond give regises own]	Salisbury	D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest II  2 Salisbury	own)				
d	NAME OF HOSPITA	L OR INSTITUTION (If not in he	apilo , give street oddress)		RE IDEN F				
		Pen Gen Hosp			NO M				
- 1	NAME OF DECEASED Type or print)	HUGH	MILTON	CORDREY DEATH January 22	Year 19 <b>59</b>				
5. S	tx Male	6. COLOR OF RACE 7. MARR		June 22, 1875  P AGE (10 years)  If UNDER TYEAR IF UNITED BY 1875  Out by bears)  Megalis Days Hours	~ <sub>1</sub> ~				
10a	USUAL OCCUPATION	N (Give kind of work dane 10b.	KIND OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT	T COUNTRY?				
	uring most of working etired Se		Boating	R.D. Mardela, Maryland U S A					
	FATHER'S NAME	JOHN CALL	2000	14. MOTHER'S MAIDEN NAME					
	William	n Thomas Cord	rev	Deliah Bradley Jackson					
15 (Yes	· · · · · · · · · · · · · · · · · · ·	AND PROPERTY OF THE PARTY OF TH		Powhaten Beach -Pasadena, Maryla					
		Enter only one couse per line	for (a), (b), and (c).]	INIT FVAL BETY ONSET ALD D	SEEIN PATA				
		MMEDIATE CAUSE (a)	Coronary occl						
	4-1011	DUE TO	J						
	Conditions, if an gove rise to immedition (a), stating the viceuse last.	ole cause	Arterio-scler	cotic cardio-vascular disease-Ye	ars .				
CERTIFICATION	PART II, OTH	er significant conditions o	ONTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS PERFI	AUTOPSY ORMED?				
	20g. EXTERNAL CAUS PRIMARY   gr CON CAUSE OF DEATH.	SE WAS TRIBUTING []	BE HOW NJURY OCCURRED (E	nter noture of injury in Part I or Part II of item 18 )					
MEDICAL	20c TIME OF INJUR Hour o.m. p. m.	Whi		CE OF INJURY (Home, form. 20f (City or lown) (County) ry, street, office bldg , etc.)	(State)				
	21. I certify that I taak charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my								
	opinion death resulted fram: Natural causes Accident . Svicide . Homicide . Undetermined manner								
	ACTUAL SIGNATURE	End C Ran	<u> </u>	_M D. CHIEF MEDICAL EXAMINER	SIGNED				
	EXAMINER'S DI	r. Earl L. Ro	yer	assistant medical examiner 5 January 26/3	1959				
220	BUR AL, CREMATION REMOVAL (SPECIE) Burial	Jan. 25, 1959	Parsons Ce	metery Salisbury, Maryland	ta)				
23	FUNERAL DIRECTOR'S	reducer or a find and all als	ADDRESS	240 REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE	PENNANA				
H	OLLOWAY 8	COMPANY SA	LISBURY MARY	LAND DATE JAN 27'59 C that & King					
-				LAND DATE JAN 27 59 C for & thouse					



1	MARYLAND STATE DEPARTM	ENT OF HEALTH—BALTIMORE, 18				
FOR STATE	MEDICAL EXAMINER	S CERTIFICATE OF DEATH Reg. Dist. No. 12439				
HEALTH DEPT.	1 PLACE OF DEATH	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on)				
	a COUNTY Wieomico MARYLAND	o STATE Maryla nd b COUNTY Wicomico				
de la	b CITY OR TOWN (1 outside corporate I mill, will to RUPAL ond give regret town)	c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)				
S. S. S.	Salisbury 8 yrs.	Salisbury				
dire	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS				
B B	316 Locust Terrace	316 Locust Terrace YES NOX				
y delay he fune retain he Stat er deat		RUMBACKER OF Jan 3/ 1959				
f an to a t	5. SEX 6 COLOR OR RACE 7. MARRIED [] NEVER MARRIED []	B DATE OF BIRTH 9 AGE IIN yaors IFUNDER TYEAR IF UNDER 24 HE				
S mg S moon	Male White WIDOWED K DIVORCED	56pc. 20, 1071 01 yrs				
r deat	during most of working life, even d retired)  Ret. Salesman  Tobacco-Whl	Maryland  11. Birthplace (State or foreign country)  Maryland  U. S. A.				
2 5 5 5 V	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
20 d de	John Crumbacker	Unknow				
Fills Fills	[You no at unbeams]         yes, supprior on dates of service	INFORMANT Address				
hin an	A STATE OF THE PARTY OF THE PAR	obtC. Crumbacker Frankfond, Del.				
Marie Da	18. CAUSE OF DEATH [Enter only one couse per ine (d) (d), (b), and (c) ]	ONST AND TOTAL				
olo olo	IMMEDIATE CAUSE (o)	Occurren Justin				
ffice frice fran frow dovo	H DUE TO QUE TO	10 de la folda de men				
A SO TO TO	Conditions, if any, which gove rise to immediate couse	the state of the s				
in i	(a), stoting the underlying DUE TO					
and	PART II, OTHER SIGNIFICANT COND TIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART TO 19 WAS AUTOPSY				
al E	5	PERFORMED? YES P NO				
ord "p Medic id be v iol, cr	200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING COURSED CAUSE OF DEATH.	(Enter nature of injury in Part 1 or Part 11 of Isem 18 )				
Though		ACE OF INJURY (Home, form, 120f, (City or town) (County) (Slate)				
THE TOTAL STATE OF THE PARTY OF	Your a.m.  P. m.  19  20c. TIME OF INJURY Month, Day, Year While Not while of work of work	tory, street, office bldg., etc.)				
A Page	21. I certify that I took charge of the remains described ob	ove, held on Autopsy . Inspection V. Inquiry V and in my				
X Z		, Suicide, Homicide, Undetermined monner				
₹ \$ 6°	8 0, 0					
Core of the core	SIGNATURE CAN KS &	M.D CHIEF MEDICAL EXAMINER [				
AL RAL	EXAMINER'S	ASSISTANT MEDICAL EXAMINER [] 2-7-59				
Poorte de	NAME (Type) Earl L. Royer	DEPUTY MEDICAL EXAMINER				
o DEI o A Sho or its	BURTAL Pecify) 1/8/1959   22c. NAME OF CEMETERY O WICO. Mem.					
VS AlsME	23, FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE				
5M 2 57	Hill & Johnson Co., Salisbury, M	larylandoam FEB 1 0 '59				
	Marce C. This is	•4				

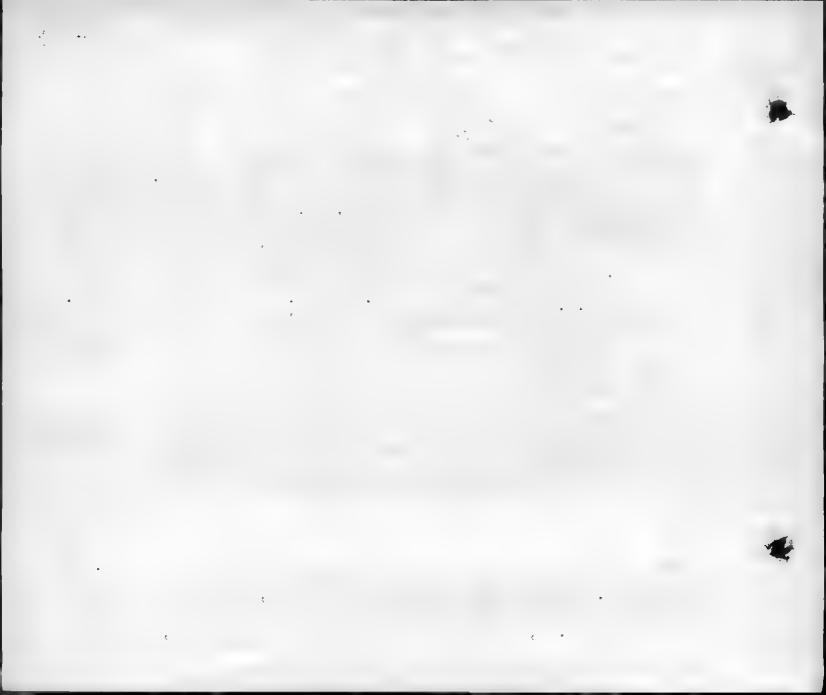


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VS A15 (4) 15M 10/57

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

	12'	73	CERT	IFIC.	ATE OF E	DEATH	1		Reg. Dist		£ 6. # 13
1. PLACE OF DEATH o. COUNTY	Wicomico		MAR	YLAND		Mary		b COUNTY		before od	
b. CITY OR TOWN (I RURAL and give no	outside corporate lim orest town! Sallsbur		c. LENGTH OF STAT	/ IN 1b	c. CITY OR 1		utside carporat	Hebro		ve nearest t	gwn)
d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospital, ) Pen Gen				STREET A		ut St			10	RESIDENCE N A FARM?
3. NAME OF DECEASED (Type or print)	HAROI	D	JACKSO	N	CULVER		4. DATE OF DEATH	Jai		14th	Year 19 59
s. sex Male	6. COLOR OR RACE White	WIDOWE	D DIVORG	ED 🗀	B DATE OF BIRTI	8,19	15	AGE (In years lost birthday) 43 yrs		YEAR IF UI	NDER 24 HRS
fruck Dr	N (Give kind of work ing life, even if retired LVEP	dane 10b.	KIND OF BUSINESS	OR INDU	STRY 11. BIRTHPL Balt	ACE (Slate	or foreign cour e , Mary	rland	12 CITI2		IAT COUNTRY
Howard J					-	n Ph	illips				
Yes no. or winnown)	R IN U. S. ARMED FOR	CES? 16	SOCIAL SECURITY NO	o. Mr	B.Elsie Hebr	M.	Culver Marvla	(Wife	"Waln	ut St	•
	TH (Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o DUE TO	, 00			THB	on h	305/2	r		ONSET AL	BETWEEN ND DEATH
Conditions, if an gave rise to it couse (a), stating lying couse fast.	ny, which ) (b	)									
5 1NC	ER SIGNIFICANT CON		EBN A	ATH BUT	NOT RELATED TO	THE TERMII	NAL DISEASE C	ONDITION GIV	EN IN PART	PER	AS AUTOPSY PFORMED?
U THE BIHER, NOTIFY	S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	206 DESC	RIBE HOW INJURY C	CCURRE	D. (Enter nature a	f injury in P	art I or Part II	of item 18.)			
20c. TIME OF INJUR Hour a. m. p. m.	f Manth, Day, Ye	While	JURY OCCURRED  Not white of work	20e. PL	ACE OF INJURY II ctory, street, office	Home, farm, bldg., etc.	20f. (City or	fawn)	(Co	runly)	(State)
21. I certify th	at 1 attended the										
actual SIGNATURE		0.	2 ond that				ADDRESS (Street	et, city or town,	state)	an./	ATE SIGNE
PHYSICIAN'S DI	r. John B	loxo	<b>m</b> 7		Sali	.sbur	y,Mary	rland			
220. BURIAL, CREMATION REMOVAL (Specify) BURIAL	Jan.17.		22c. NAME OF CEM Hebron					N (City, town, o		_ *	tate)
HOLLO NAY &		SA	ADDRESS T.T.SRIIRV	MAR	YT AND	240. REC'D	BY REGISTRA		TRAR'S SIGN		



23. FUNERAL DIRECTOR'S SIGNATURE

HOLLOWAY & COMPANY

MARYLAND	STATE	DEPARTMENT	OF HEALTH-BALTIMORE,	18
It	ems 8	1.4 File 2358	1-33-59 et	

CERTIFICATE OF DEATH

Rea, Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission o. COUNTY o. STATE Wicomico **b** COUNTY Maryland MARYLAND Wicomico b CITY OR TOWN (If outside corporate limits, write C. LENĞTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)
Salisbury Salisbury d NAME OF HOSPITAL (If not in hospital, give street address) d/ STREET ADDRESS . IS RESIDENCE OR INSTITUTION R.D.# ON A FARM? R.D.# YES NO D 3 NAME OF 4. DATE Middle DECEASED OF VIRGINIA Α DASHIELI JAN. 15th (Type or print) DEATH 10 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In years B DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys Hours Female White DIVORCED [" WIDOWED T 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 12 CITIZEN OF WHAT COUNTRY during most of working life, even if retired) S Maryland House Work 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Hester Webster Samuel Shockley 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Iris Layfierd R.D.# 2 (Yes, no or unknown) (If yes, give war or dates of service) No Salisbury, Maryland CAUSE OF DEATH [Enter only one couse per line for (o), (b) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove rise to immediate **DUE TO** couse (o), stoting the underlying couse lost. FICATION PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(G) 19 WAS AUTOPSY PERFORMED? YES 🗍 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, 20e PLACE OF INJURY (Home, form, 20f (City or town) 20d INJURY OCCURRED Day, Year (County) (State) Hour a.m. factory, street, office bldg., etc.) While Not while of work of work p. m 21. I certify that I attended the deceased from ...that I last saw the deceased M. from the causes and an the date stated above. alive on. and that death accurred at 1 DATE SIGNED ADDRESS (Street, city/or lown, state) ACTUAL C.Mitchell Salisbury, Maryland Dr. Andrew Ave. NAME (Type) 220 BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, lown, or county) (Stole) REMOVAL (Specify) Parsons Cemetery Salisbury Maryland

240 REC'D BY REGISTRAR

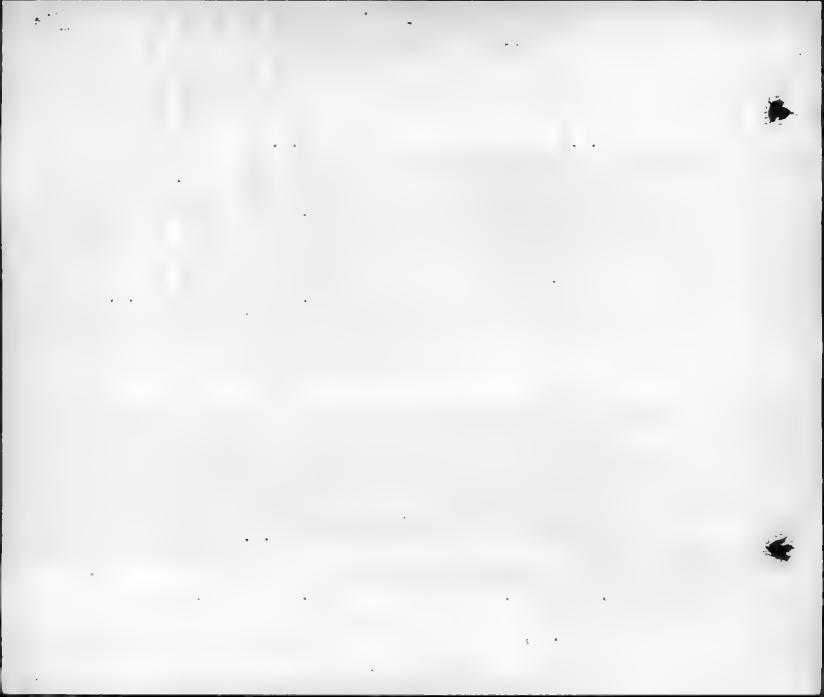
DATE . TAN 2 0 '59

246 REGISTRAR'S SIGNATURE Cathan & Heart

**ADDRESS** 

SALISBURY MARYLAND

0 VS A15 (4) 15M 10/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Rea, Dist. No. 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admiss an COUNTY g. STATE b. COUNTY MARYLAND Maryland Somerset Wicomico b. CITY OR TOWN (if autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporale limits, write RURAL and give nearest town) Westover Salisbury 9 days d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Deer's Head State Hospital d. STREET ADDRESS e IS RESIDENCE ON A FARM? Rt. #1. Box 18 YES NO F 3. NAME OF First 4. DATE Middle George Davis DEATH (Type or print) January 19 59 6. COLOR OR RACE 7- MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS last birthday) Months Days Hours Male Negro WIDOWED [7] DIVORCED [7] bon popers. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY death. during most of working life, even if retired) USA . Thurmann MC 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 500 IS WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address Unk Hospital Records, Salisbury, Maryland CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c) ] INTERVAL BETWEEN ONSEL AND DEATH Carcinoma of stomach with metastases PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate DUE TO cause (a), stating the underlying couse last. burial-transit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS PERFORMED? Gangrene of rt. leg due to sclerotic vascular changes YES NO DO 200 ACCIDENT WAS UNDERLYING () 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING () CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e PLACE OF INJURY (Home, form, | 20f (City or town) Day, Year 20d, INJURY OCCURRED (County) (State) factory, street, affice bldg, etc.) Haur a.m. Not while While al wark 21. I certify that I attended the deceased from Jan. 6 19 59, to Jan. 15 19 59, that I lost saw the deceased ., 19.59..., and that death accurred at 12:30PM, from the causes and on the date stated above ADDRESS (Street, city or lown, state) DATE SIGNED ACTUAL SIGNATURE · M.D Deer's Head State Hospital PHYSICIAN'S V. Juerman, M. D. Salisbury, Maryland NAME (Type)

22c NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town, or county)

24b REGISTRAR'S SIGNATURE

240. REC'D BY REGISTRAR

(Stote)

AS VIOLEN TO FUNEZAL DIRECT POSE 3 should be de the registror prior to

270. BURIAL CREMATION. 22b. DATE THEREOF

#EMOVAL (Specify)

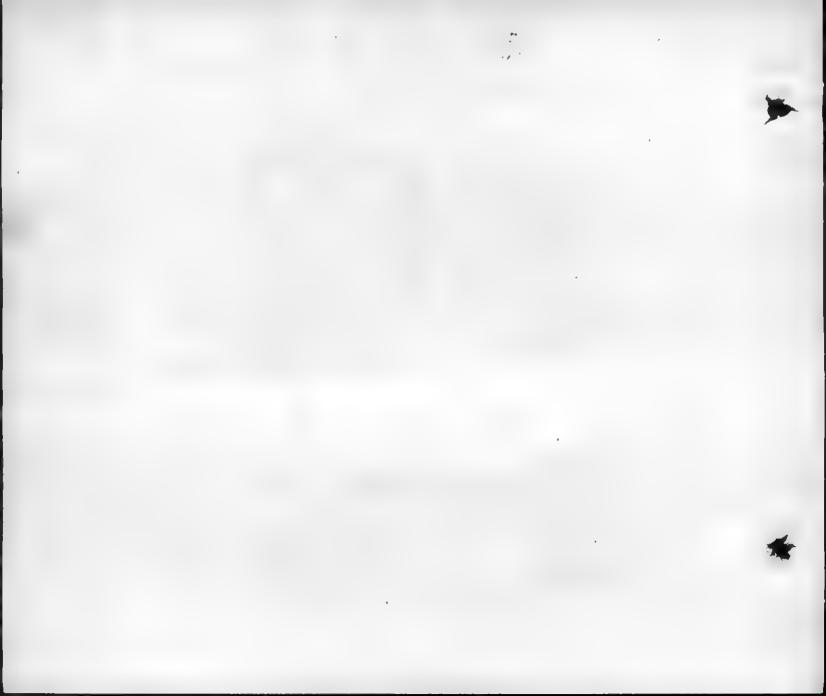
23. FUNERAL DIRECTOR'S SIGNATURE

Page 4

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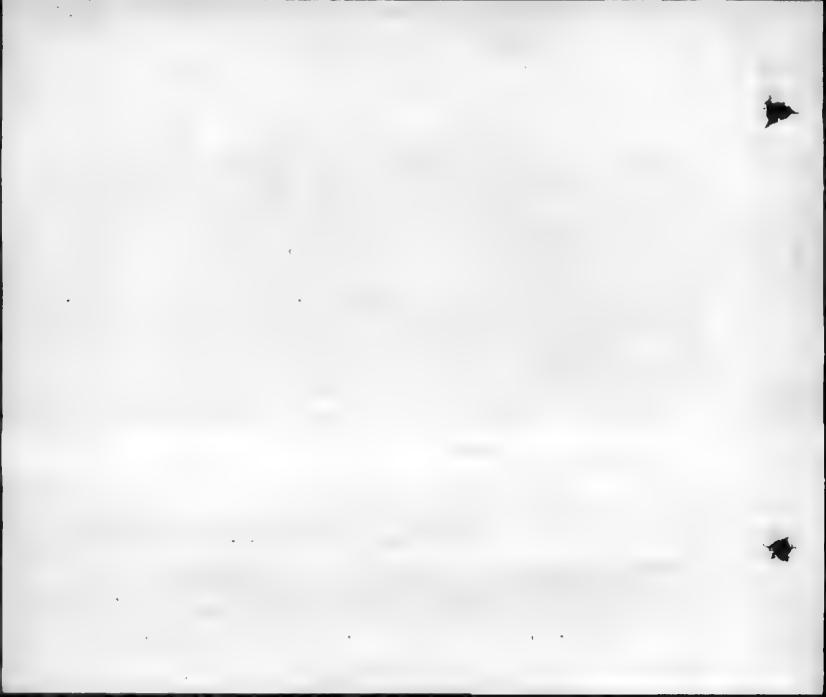


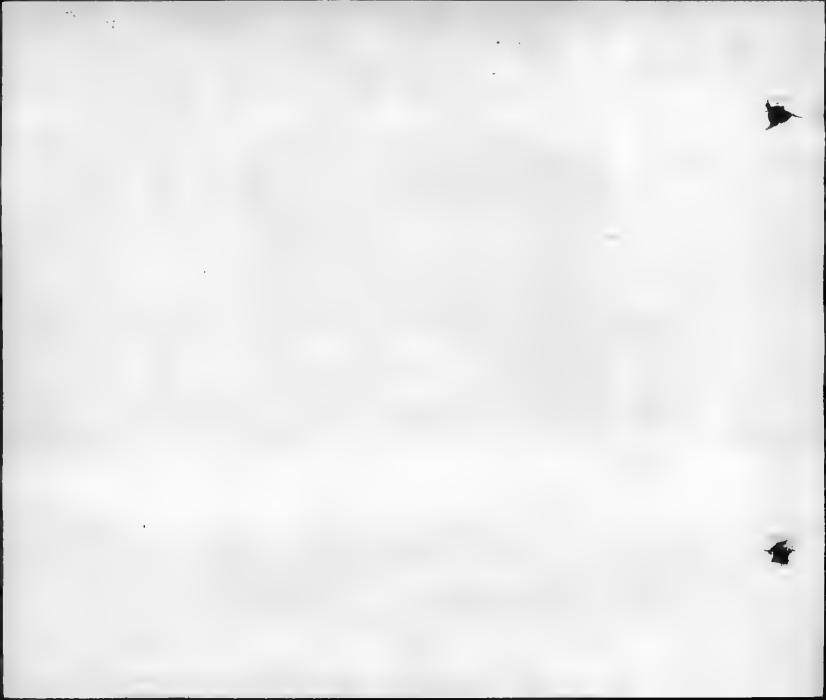
		1961	CEKIIFIC	AIE OF DEAT		Reg.	Dist. No.	
``	PLACE OF DEATH	Wicomico	MARYLAND	2. USUAL RESIDENCE (W		I If institution Reside. COUNTY	dence before odm Wicomi	
-	b. CITY OR TOWN RURAL and give v	(If outside corporate limits, write learns fown) Hebron	c LENGTH OF STAY IN 16	c. CITY OR TOWN (IF		mits, write RURAL or	nd give nearest to	wn)
	d NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, give street of Walnut St	oddress)	M. STREET ADDRESS Walt	nut St		ON	ESIDENCE A FARM?
	3. NAME OF DECEASED (Type or print)	KATHRYN	Middle ELLEN	DISHAROON	4. DATE OF DEATH	JANUA.	RY 15	Yeor 19 59
	5. SEX Female	6. COLOR OR RACE 7 MARR WIDOWE	DIVORCED		, _ / _ / _ /	9 yrs Mopth	DER TYEAR IF UN	
	Employee	ON (Give kind of work done 10b. king life, even if retired) -Shirt Factor		JSTRY II BIRTHPLACE (Stone Hebron, I			CITIZEN OF WHA	
)	Robert I	ee Lowe		Dollie E				
	15. WAS DECEASEDEN	ER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO Mr	Hebron, Ma	sharoon	(Soff)Wa	lnut St	•
	Conditions, if c gove rise to cause (o), stoling lying cause lost.	the under DUE TO  (c)  HER'S GNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BU				ONSET AN  ART I(o) 19 WAR  PER  YES [	S AUTOPSY FORMED?
	OR CONTRIBUTING	GLI CAUSE OF DEATH MEDICAL EXAMINER)  RY Month, Day, Year 20d. IN		ED. (Enter noture of injury in LACE OF INJURY I Home, for actory, street, office bidg., et	n, 20f. (City or to		(County)	(State
	21. I certify the alive an	White of work not I attended the decease of the second of	ed fram / 7	19.27 to 9 h accurred at 10:2	leath		I last saw the the date sta	e decease ited abov  DATE SIGN  (195)
	220. BURIAL CREMAT C REMOVAL (Specify BUT12	n. 226. DATE THEREOF 1-Jan. 18, 1959	22c. NAME OF CEMETERY C			City, fown, or county, I		o'e) d
	23. FUNERAL DIRECTOR		ADDRESS		D BY REGISTRAR	246 REGISTRAR'S	SIGNATURE	
	HOLLOWAY	& CUMPANY SA	LISBURY MAR	YLAND DATE	IAN 1 9 '59	Cirching	2 Hours	

eoth. Poge 4 director, filed with ATTENDING ENYSICIAN: The lom requires that the death certificate be axecuted within 24 hours after in by y the attending physician and completely filled. Then please remove carbon papers. Pages 1 event within 72 haugs-after death. may be retained by the hospital or attending physician.

O FUNERAL DIRECT, After this certificate has been signed by page 3 should be defached for use as the burial-transit permit, the registrar prior to burial, cremation, or remaval, and in ony expension.

TO FUNERAL DIRECT TO HISPITAL OF VS A15 (4) 15M 10/57





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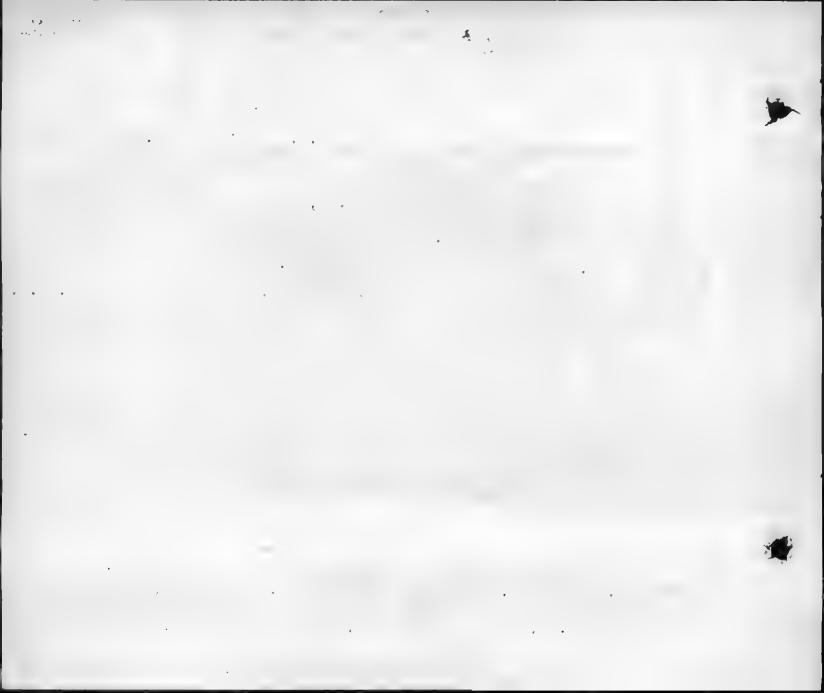
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FUNERAL DIR

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



FUMERAL BIRECTOR'S SIGNATURE

ADDRESS/

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 111282 **CERTIFICATE OF DEATH** Rea. Dist. No. 2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) **b.** COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GIRDLE TRIL d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO ! 4. DATE Month Day Year DEATH 19 55 SANUAR AGE ( n years IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 11 BIRTHPLACE (State or Toreign count) 12. CITIZEN OF WHAT COUNTRY? 14 MOTHER'S MAIDEN NAME 17 INFORMANT Address INTERVAL BETWEEN ONSET AND DEATH PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? NO F 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) [County] (Stole) factory, street, office bldg., etc.) that I last saw the deceased and that death occurred at 52 74.M, from the causes and on the date stated above. ADDRESS (Street, gily or town, slote) DATE SIGNED 22d COCATION (City town, or county) (Stote 240. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE

0 VS A15 (4) 25M 10/57



VS A15 (4) 15M 10/57 I

1277 CERTIFICATE OF DEATH

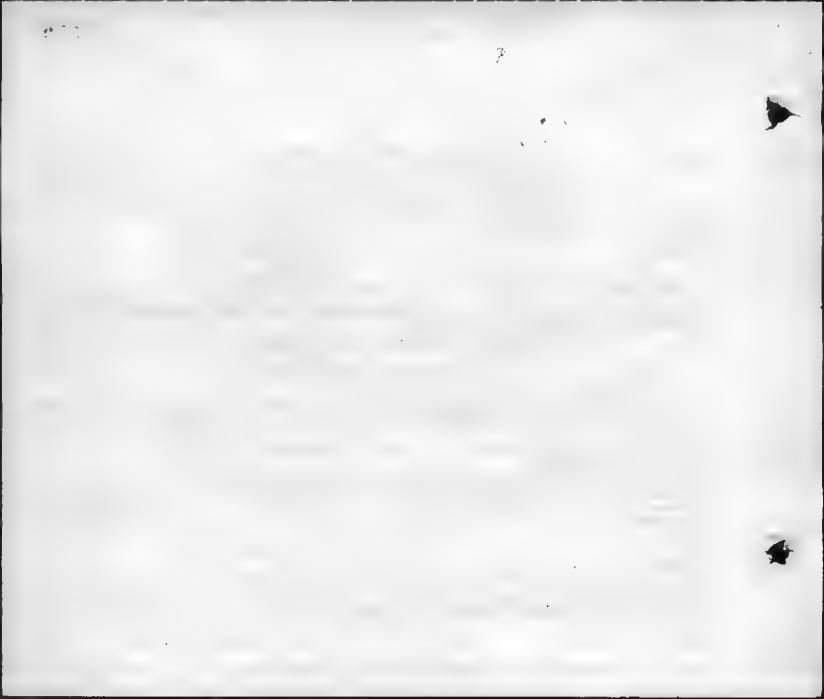
Ren.	Dist.	No

1 PLACE OF DEATH	2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
· COUNTY WICOMICO MARYLAND	· STATE MARYLAND & COUNTY WICCOMICO
b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16	c CITY OR TOWN of outside corporate limits, write RURAL and give nearest town)
SALISOURY	SALISHURY.
d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	d. STREET ADDRESS e IS RES DENCE
310 GAY STREET	310 GAY STREET VES NO E
3 NAME OF First Middle	last 4. DATE Month Day Year
(Type or print) CHARLES W.	GALE DEATHS ANUARY 1 1959
5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH  9 AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS  lost bigthdoy)  Months Days Hours Mun
MALE While WIDOWED DIVORCED	MAY 23, 1875 63 m
10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS	TRY 11 PRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY
PLUMBER PLUMBING	MARYLAND U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE GALE	UNKNOWN
15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 IP	NFORMANT Address 11 12 Q and
NO NO DE	2. Rufus Johnson SNOW WILL KOAG
18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]	OALISD WHITERYAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Shair
DUE TO	101000
Conditions, if ony, which } in Acute, we have	chaul.
gove rise to immediate	
lying couse lost.	
	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	PERFORMED? YES NO
200. ACCIDENT WAS UNDERLYING   206 DESCRIBE HOW INJURY OCCURRED	(Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH  [IF EITHER, NOTIFY MEDICAL EXAMINER]  20b DESCRIBE HOW INJURY OCCURRED  20c DESCRIBE HOW INJURY OCCURRED	
	ICE OF INJURY (Home, form, 20f (City or town) (County) (Slate)
While Not while of work of work	A .
21. I certify that I attended the deceased from hellmille	31. 1958, to January 174959, that I last saw the deceased
1.1/7	occurred of 2 NA EXM, from the couses and on the date stated above
	ADDRESS (Street, city or Jown, state)  DATE SIGNET
SIGNATURE SI VILL NEW MAN	10. 2 NON. Kinisim W
0 11 11 11	
PHYSICIAN'S HURTE HE ARN,	2261. Nel Meser 1786
220. BURIAL, CREMATION, 22b DATE THEREOF 22c NAME OF CEMETERY OF	CREMATORY 22d. LOCATION (City, town, or county) (Stole)
BURIAL 1-3-1959 PARSONS	COMGIERY SALISBURY MARYLAND
23. FUNCAND DIRECTORY SIGNATURAL SADDRESS ADDRESS ADDRESS ADDRESS ADDRESS	240. RIC'O BY REGISTRAR 246 REGISTRAR'S SIGNATURE
/ Jumes / Cultural Control	DATE JAN 3 33



1979\_tem 6 CERTIFICATE OF DEATH 01284 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. COUNTY O. STATE h COUNTY MARYLAND b. CITY OR TOWN, (If outside carporote limits, write RURAL and give negres) town! C. LENGTH OF STAY IN 15 c. CITY OR TOWN TIP outside corporate limits, write RURAL and give negrest town) d. NAME OF HOSP IALAS not in hospital, give street address) d. STREET ADDRESS e 15 RESIDENCE ON A FARM? YES T NO T NAME OF Middle 4. DATE Lost Month Day Year DECEASED OF (Type or print) 10/4 DATE OF BIRTH IF UNDER 1 YEAR HE UNDER 24 HE MARRIED NEVER MARRIED Months Dove Hours Min papers. DIVORCED WIDOWED [ 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State and areign country) during most of working life even if retired) A P 12. CITIZEN OF WHAT COUNTRY ian and carbon g ð 13. FATHER'S MAME e 14. MOTHER'S MAIDEN NAME physician off D certificate move IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17 INFORMANT Add/ets CALLEE OF DEATH [Enter only one couse per line for (a), (b), and (c) INTERVAL BETWEEN à PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 DUE TO ä: Conditions, if any, which Bued gove rise to immediate DUE TO Per l couse (a), stating the underpup lying cause tost. -transit peen : PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS ALTOPSY remayal. burial NO P YES | 20a. ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Hame, farm, 20f. (City or fawn) Day, Year 20d. INJURY OCCURRED (County) (State) Hour o. ri. factory, street, office bldg., etc.) While Nat while of work of work p. m. ... 1957 that I last saw the deceased 27 alive on\_ \_\_\_\_, and that death occurred at 300PM, from the causes and on the date stated above. ADDRESS (Street, city or fawn, state) DATE SIGNED ACTUAL SIGNATURE RAL DII PHYSICIAN'S 15 NAME (Type) ohn 20 104 3.6 FUNE oge 3 BURIAL CREMATION, 200. DATE THEREOF 22E DIAME OF CEMETERY OR CREMATORY 22d )LOCATION (City, town, or county) page the re (Stole) 0 BUNERAL DIRECTOR'S SIGNATURE ADDRESE 245. REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR DATE TAN 2 9 159 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours offer

VS A15 (4) 15M 10/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1279 CERTIFICATE OF DEATH

Reg. Dist. No. 01285

1.	PLACE OF DEATH o. COUNTY WI	comico		MARYE	AND	2. USUAL RESIDENCE ( o. STATE Mary	(Where decess	ed lived. If institute b COUNTY	_	hest		
	Salisbu	iry		c. LENGTH OF STAY I		c. CITY OR TOWN (	oridge	orote limits, write R	URAL and gi	ive neares	t town)	
	OR INSTITUTION	Mead State		,		d. STREET ADDRESS RFD #					S RESIDENCE ON A FARM? ES NO	
3	NAME OF DECEASED (Type or print)	Lott		Middle		Gootee	4. DATE OF DEATH	Mon Jan		Doy 7	Yeor 19 59	
	sex Female	White	WIDOW	and the same of th		10/24/189		9. AGE (In years lost birthday) 05 yrs			UNDER 24 HI	ts_
	o. USUAL OCCUPATION during most of world ?  FATHER'S NAME	ON (Give kind of work king life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUS	Maryla	nd	country)		USA	VHAT COUN	ry
	Jerome				·	14. MOTHER'S MAIDER						
15. (Ye	?	(If yes, give wor or dates of s	ervice}	SOCIAL SECURITY NO.	17 IN	FORMANT Hospi	tal Rec	cords Add	ress.			
		TH WAS CAUSED BY:	1A	ne for (o), (b), ond (c) ] arterioscles	roti	c cardiovas	INTERV	ONSEY AND DEATH				
	Conditions, if o gove rise to it couse (p), stoling lying couse lost.	mmediate (	)£	Arterioscle	rosi	s, generali	zed			Y	ears	
FICATION		IER SIGNIFICANT CON	Old	d cerebral t	thro				EN IN PART	P	VAS AUTOPS ERFORMED? S NO D	
AL CERTIF		S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)		4		. (Enter nature of injury i						
MEDICAL	20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Day, Yes	While	Not while of work	fact	CE OF INJURY (Home, fo ory, street, office bldg., i	etc.)		•	onty)	(Slot	·
	ACTUAL	ot lottended the Jan. 7	12.5 ~ l	ele ,			ADDRESS (S	m the causes a lireet, city or lown, late Hospi	nd an the	st sow e date :	the decea stated abo DATE SIGN 7/59	ıve
220	BURIAL, CREMATION REMOVAL (Specify)	1-9-59	F	22c. NAME OF CEMET		CREMATORY	22d LOCA	TION (City, town, a bridge,			(Stote)	
23.	FUNERAL DIRECTOR'S	SIGNATURE 2	/	ADDRESS			C'D BY REGIST		TRAP'S SIGN			



ON A FARM?

Day

IF UNDER TYEAR IF UNDER 24 HRS

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND, DEATH

MILES

PERFORMED? YES NO

(State)

DATE SIGNED

(Stole)

Days

USA

(County)

YES 🔲 NO 🗗

Yeor

59 19

Rea. Dist. No.

Wicomico

Months

director, ifed with Pied hours pluods

that

PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland COUNTY b. COUNTY MARYLAND Wicomico b. CITY OR TOWN (If outside carporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Sharptown Sharptown vears d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION d. STREET ADDRESS Main Street 26 Main Street 9 NAME OF First Middle 4. DATE Month DECEASED DEATH Jan. Kennerly (Type or print) Grace Gravenor 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years 5. SEX B. DATE OF BIRTH los (birthday) Sept. 18,1880 Female White WIDOWED IX DIVORCED [7] 100. USJAL OCCUPATION [Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) Maryland Home Home 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME physicion Mary Margaret Bennett Andrew J. Kennerly 17. INFORMANT WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Mary Russell. Sharptown. Md. No None 1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c) ] PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO à Conditions, if any, which gove rise to immediate **DUE TO** couse (o), stating the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY 20o. ACCIDENT WAS UNDERLYING [] 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) Doy, Year factory, street, office bldg., etc.) Hour a.m. Nat while of work of work 22629 . 19 5 9 that I last saw the deceased 21. I certify that I attended the deceased from Land that death occurred at 11214M, from the causes and an the date stated above. alive on ADDRESS (Street, city or town, state) ACTUAL Id b PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION, 226. DATE THEREO! 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) REMOVAL (Specify) Buria Riverton. Riverton 0 23 EUNERACIDIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE

Maryland

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FOR STATE HEALTH DEPT.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

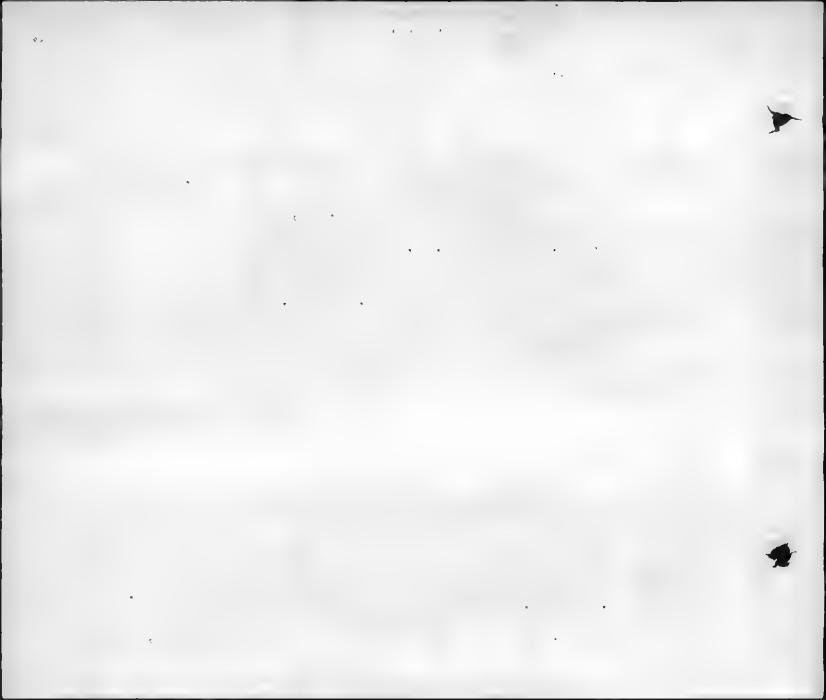
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, r													
/	a. COU	OF DEATH	Wicomi	co		MARYLAND	2. USUAL RE a STATE		yland	lived. If in b COt	stilution: Reside		odmission) M1CO
	b. CITY	OR TOWN I	Salisb		c. LENGTH O	F STAY IN 16	e. CITY O	~ ~ ~	l sbur		rite RURAL and	give near	est town)
	d. NAM	AE OF HOSPIT		ION (If not in h	# 83)	address)	d STREET		eway	(Box	#83)		IS RE' DEN' E ON A FARM? ES NO
	3, NAME DECEAS (Type o	OF SED or print)	ALE	XANDER	Mid	ddle G	RIFFI	4	DATE	·	onth 9th	Doy	Yeor 19 59
	s. sex Maj	le	6. COLOR OR Whit		RIED   NEVER A	AARRIED   8	Dec.	17.190	,3	AGE (In year lost birthday)	7	-	UNDER 24 HKS
	100. USUA during r	NE OCCUPATIONS OF WORKS	ON (Give kind of ng life, even if re	work done 10b	r Adv. C	SS OR INDUST			r foreign cou	intry)		ZEN OF W	HAT COUNTRY?
		R'S NAME	Griffit				14. MOTHER'S	MAIDEN NA	ME		1		
	(Yes, no, or	DECEASED EV	(If yes, give war or	ED FORCES?   1.	S SOCIAL SECURIT	urş	Susi Box #	e A. Ho	ollow	ay(Mo	ther)P		
	18. C/		TH [Enter only of TH WAS CAUSED IMMEDIATE CAU	BY.	• for (0). (b), and	(c).]	Dx	elus	Lyn		- +->	INTER AL ONNET AN	
,	gove (o), s couse	ditions, if c rise to imme stating the e tast. PART II, OT	diote come underlying	(b)	CONTRIBUTING TO	D DEATH BUT N	OI RELATED TO	THE TERMIN	AL DISEASE (	CONDITION	GIVEN IN PART	P	ERFORMED?
	- 1		USE WAS NTRIBUTING []		IBE HOW INJURY					, 	T and the same	TAER	
	0	Hour o.m.		W	INJURY OCCURI ple Not while work at work	efacto	E OF INJURY ry, street, offic	(Home, form, e bldg , etc )	20f (City o	r lown)	(Cou	nly)	(Stote)
	1			_	causes		_	Autopsy le [], Ho		pection [	(), Inquir	15.50	ond in my
	ACTU	JAL	El	LR	yer/		, M.D.	MEDICAL EXAI		П		D	ATE SIGNED
,	NAM	MINER'S DI		-	yer_	needs sheeting on	DEPUTY	MEDICAL EX	AMINER [X		Jan.	10	/1959
	REMO	Bur1	att han.	13,195	9 Pars		meter	y I	Sa	lisbu	rn, or county)	2-JH	(State)
			& COMP	ANY S	ALISBUR	Y MARY	TAND	DATES 1	4 '59		EGISTRAR S SIG		

TO DEPUTY MEDICAL EXAMINER: This certificate shauld be executed within III have after Beath. If any delay is necessary, please execute the certifier, writing the ward "pending" in pendil in them. 18. Give Pages 1, 2, and 3 to the funeral dir for. Page 4 shauld be for the fat the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a buriol-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to buriol, cremation, or removal, and in any event within 72 hours ofter death. VS. A15ME 5M 2 '57

1



Page 1

along with form PM3.
I permit. File pages 1

Office

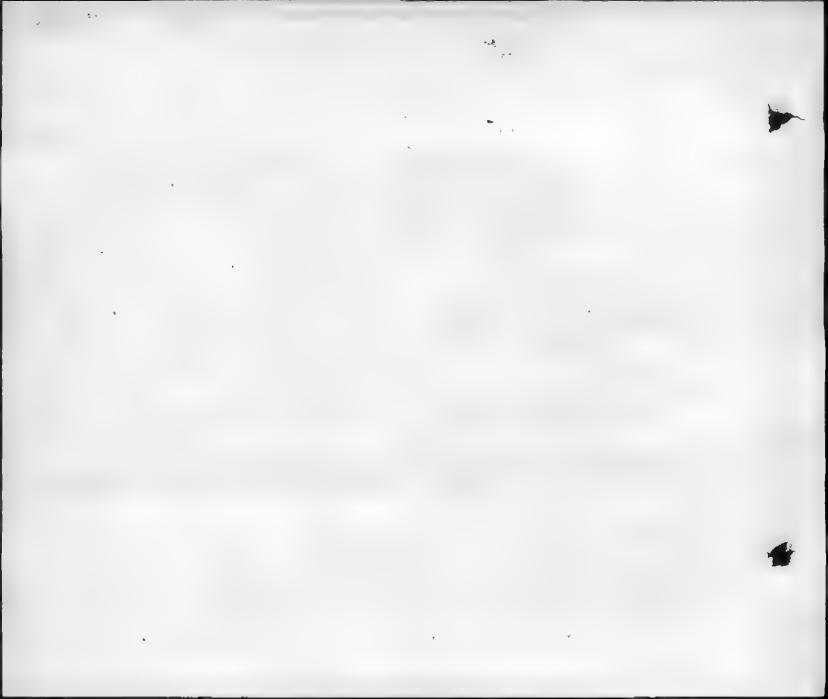
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Should FUNER

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VS. ATSME

event

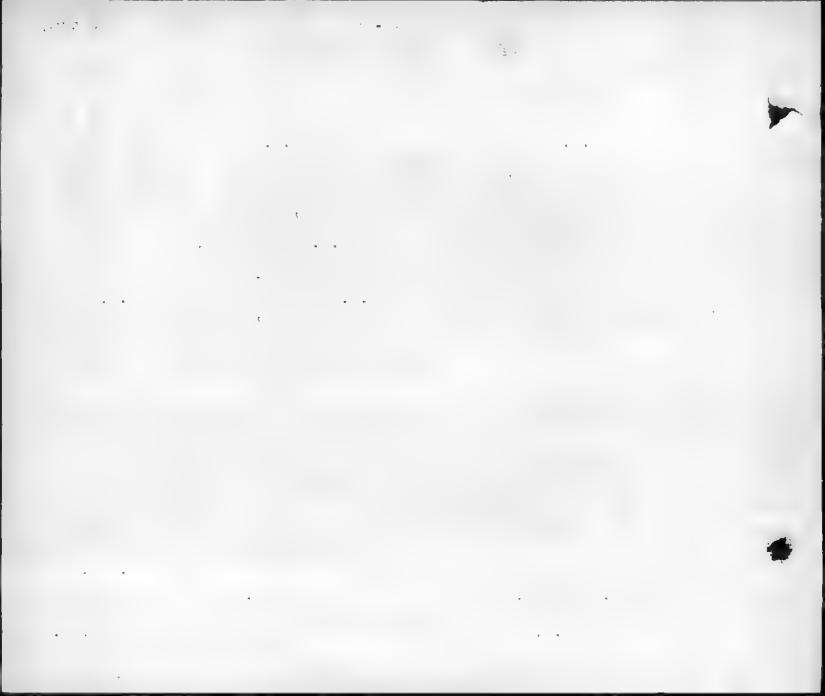


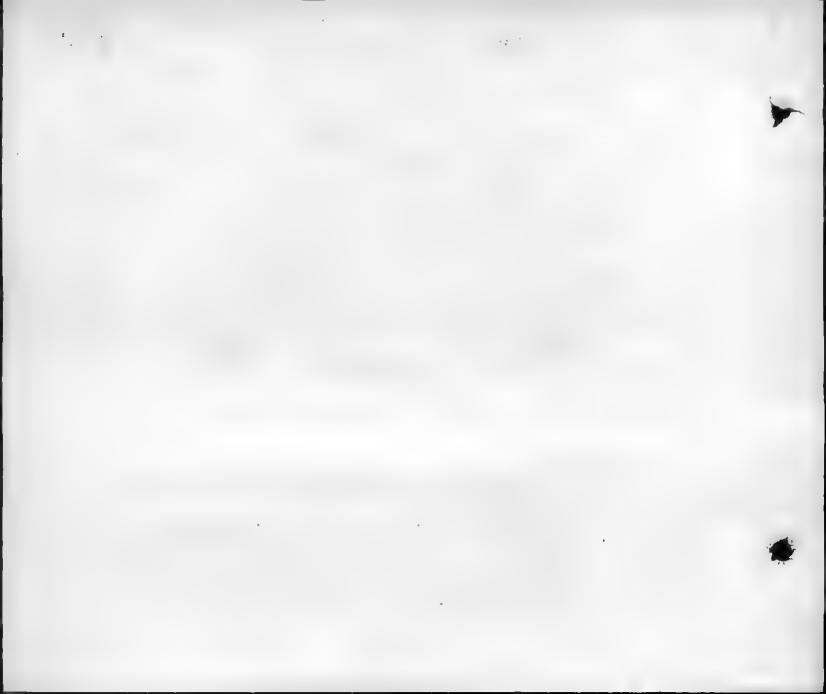
VS A1S (4) 1SM 10/S7 01283

1325 CERTIFICATE OF DEATH

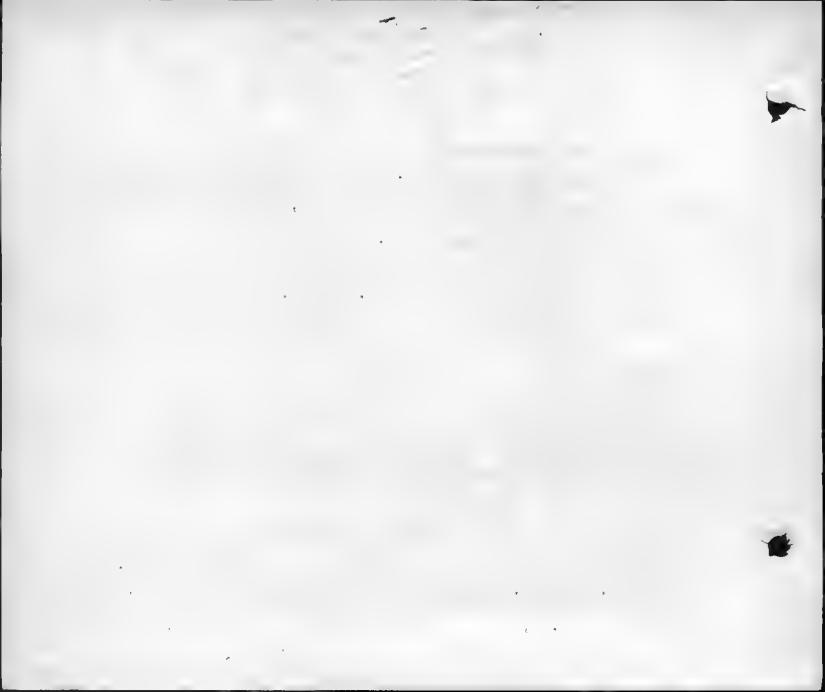
Reg. Dist. No.

1	1. PLACE OF DEATH o. COUNTY W1COM1CO	MARYLAND	2. USUAL RESIDENCE (Where o STATE Mary	e deceased lived If institution Residence 71and b. COUNTY W10	ce before odm ssion)
5 1	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). Pittsville	c. LENGTH OF STAY IN 16	_ '	side corporote limits, write RURAL and g	give nearest town)
")	d. NAME OF HOSPITAL (If not in hospital, give stree or institution $R_{\bullet}D_{\bullet}\#$ ]	oddress)	d. STREET ADDRESS R.D.	# 1	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF First DECEASED (Type or print) VIRGIL	Middle LEE	HAMMOND 4	DATE Month OF JANUARY	30th 19 59
	5. SEX 6. COLOR OF RACE 7. MAI White Widow	/ED DIVORCED D	June 21,188	39 last hirthday) Months	TYEAR IF UNDER 24 HRS Days Hours Min
	100 USUAL OCCUPATION (Give kind of work done 10th during most of working life, even if retired) Farmer & Chicken Gro	KIND OF BUSINESS OR INDUS	R.D.# Sal	foreign country)   12 CITI Lisbury, Md.   U	J S A
1	13. FATHER'S NAME	3	14. MOTHER'S MAIDEN NAM		
1	William James Hammon  Is was deceased ever in u. s. Armed Forces?  If yes, grown or or dof at of server)  Unk		s.E.Blanche	E. Bethards Hammond(Wiffe)R. Maryland	.D.# 1
	18. CAUSE OF DEATH [Enter only one couse per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o).  Conditions, if ony, which gove rise to immediate couse (o), slating the under-lying couse lost.  Part II OTHER SIGNIFICANT CONDITIONS	me fork	of Frency  assex to 5	Cuifle Liver AL DISEASE CONDITION GIVEN IN PART	INTERVAL BETWEEN ONSET AND DEATH  1 (a) 19 WAS AUTOPSY PERFORMED? YES TO NO [X]
	OR CONTRIBUTING   CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER]  20c. TIME OF INJURY Month, Day, Year 20d. Hour o. m. While		(Enter nature of injury in Por ACE OF INJURY (Home, farm, fory, street, affice bldg., etc.)		Caunty) (State)
-	21. I certify that I attended the decear alive on Sucry 29, 19  ACTUAL SIGNATURE C. H1  PHYSICIAN'S Dr. Thomas C. H1	sed from November 59, and that death	occurred at 35A	M. fram the causes and an the the state (Street, city or town, state)  Jan.  Rd. Salisbury, Ma	DATE SIGNED  1959
	220 BURIAL CREMATION, 226. DATE THEREOF BURIAL Feb. 1, 1959	20: NAME OF CEMETERY OF Pittsville	Cemetery(Q1	2d LOCATION (City, lown, or county) Ld-Part) Pittsvi	(Stote)
	23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		BY REGISTRAR 246 REGISTRAR'S SIG	
	HOILOWAY & COMPANY S	ALISBURY MAR	ALTAND PEER 3	'59   1 lar 8 1	4









HEALTH DEPT.

I PLACE OF DEATH

a. COUNTY

3. NAME OF

5. SEX

DECEASED

(Type or print)

13. FATHER'S NAME

0

with form PM3. should FUNER

70 IVS. ALSME 5M 2/57

DEP

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 28 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Rea, Dist. No. 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY Delaware MARYLAND Wicomico b. CITY OR TOWN Ist outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frankford Salisbury d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS . IS RE ID'N I ON A FARM? Peninsula General YES 110 4 4. DATE Middle Year 1059 1.0 H: 11 DEATH Geraldine 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF B RTH 9 AGE |lin years IFUNDER TYEAR IF UNDER 24 HRS Months Новти WIDOWED | Feb.15.1959 DIVORCED T 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY , 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Acad sek Courty, Va. 14. MOTHER'S MAIDEN NAME Mariie Odessa Williams James Hill 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Iff yes, give war or doles of service) Marjie Hill, Onangoals 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: Bullet wound of brain hours IMMEDIATE CAUSE (6) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), sloting the underlying PERFORMED? NO [ 200. EXTERNAL CAUSE WAS PRIMARY (ZLor CONTRIBUTING ) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

cause fast. PART II. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY

Inquiry X

and in my

(Stote)

CAU	SE OF DEATH.		Byst	ander	shot	while	two	men v	vere	fight	ing (	over	gun
		Manth, Doy, Y	reor 20d	. INJURY OC	CURRED 20	. PLACE OF IN.	URY (Home,	form, 20f	(City or lows	)	(Count)		(Sto
٦	· TOP A. M.	1-10	259 or	work of w	rork K	HiHat	Club		Ocean	City			Md.
21.	I certify that !	took charg	ge of the	remoins (	described	above, hel	d an Auto	ODSY X.	Inspect	ion T	Inquiry	[7] 0	nd in

opinion death resulted from: Natural causes . Accident X. Suicide . Homicide . Undetermined manner

ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER SIGNATURE

ASSISTANT MEDICAL EXAMINER [7] **EXAMINER'S** 

NAME (Type) Earl L. Royer, DEPUTY MEDICAL EXAMINER 220 BURIAL CREMATION, 226 DATE THEREOF 72c NAME OF CEMETERY OR CREMATORY 27d LOCATION (City, town, or county)

REMOVAL (Specify) Cemeteru Accompak 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 246. REGISTRAR'S S GNATURE

ACCC . C. Vir, il i CDATE



01294

**CERTIFICATE OF DEATH** 1284

Reg. Dist. No.

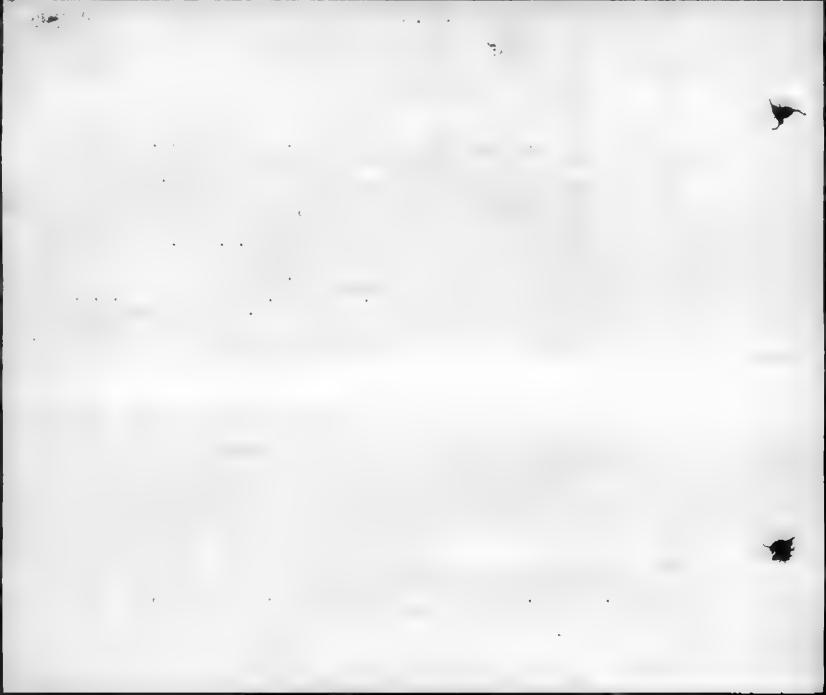
\	1. PLACE OF DEATH • COUNTY	Wicomico		MARYL	AND	o. STATE Mary	here deceased	lived. If institution b. COUNTY		fore odmiss	
/	b. CITY OR TOWN ( RURAL ond give n	If outside corporate limit eorest town) Sallsbur		c LENGTH OF STAY IN	V 16	c. CITY OR TOWN (IF O	outside corpora	ote limits, write RU	JRAL and give n	egresi town	)
,	d NAME OF HOSPI OR INSTITUTION	Pen Gen.				d STREET ADDRESS	Termon	Rd(P.C	B#708	e IS RES ON A YES	IDENCE FARM?
	3 NAME OF DECEASED (Type or print)	Fire FDW	ARD	Middle CAT.V	TN	HOLLOWAY	4. DATE OF DEATH	JAN.		-/	Yeor 10 59
	s. sex Male	212211	* * * * * * * * * * * * * * * * * * * *	IED NEVER MARRIED		B DATE OF BIRTH	9	AGE (In years last last last last last last last las	IF UNDER I YEA		.,
~	100. USUAL OCCUPATION during most of work Wher-Oper	ON (Give kind of work of	ione 10b.	KIND OF BUSINESS OR	INDUS	TRY 11. BIRTHPLACE (SIGNES) Snow Hil	or foreign cou		12 CITIZEN	OF WHAT	COUNTRY
	R3. FATHER'S NAME	7	2			14. MOTHER'S MAIDEN N					
/	IS, WAS DECEASED EVE	alvin Hol		SOCIAL SECURITY NO	17 18	Mary C.		_			1
	NO or unknown)	(M yes, give wor or dates of si	rvice)		Mr	s.Pauline I Mt Hermon	.Holl	oway(Wi Salist	re)P.C	B.#	708 ind
		ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o		e for (o), (b) and (c) ]	·~	ong o a	lunio	~/	26	TERVAL BE	DEATH
	Conditions, if a		-	Reterior 1	sel	levotie h	eart	die	٠ ١	m	-
	couse (o), stating lying couse lost.	the under-			_					7	
	CAT		DITIONS C	ONTRIBUTING TO DEAT	H BUT	NOT RELATED TO THE TERMI	INAL DISEASE	CONDITION GIVE	N IN PART 1(o)	PERFO	AUTOPSY RMED? NO X
		S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	RIBE HOW INJURY OCC	URRED	. (Enter nature of injury in I	Part I or Part I	of stem 18.)			
	20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Day, Yec	While	UURY OCCURRED Not while of work	De. PLA foct	CE OF INJURY (Home, form lory, street, office bldg., etc.	20f. (City o	or fown)	(County	)	(Stote)
	21. I certify th	at I attended the	decease	ed from	77	, 19.54, to	1-10	1959	that I last s	aw the	decease
	alive on	10	_, 125	and that d	leath	accurred at 12 7	M, from	the causes as	nd an the de	ate state	d abave
	ACTUAL SIGNATURE	Enl	/	Ex.	A	A.D			nuary		TE SIGNE
	PHYSICIAN'S NAME (Type) DY	. Farl L.	Roy	ver ()		Camden Ave	s. Sa	lisbury	,Mary	and	
	220 BURIAL, CREMAT O REMOVAL (Specify)	Jan. 14/		Wicomic		CREMATORY Memorial Pa		Salisbu		y]ar	
	23. FUNERAL DIRECTOR			ADDRESS	π Λ D:	E F S T	D BY REGISTRA		TRAR SEIGNATE		

eral director. Be filed with O FUNERAL DIRECTION After this certificate has been signed by the attending physician and campletely filled in by page 3 should be dejected for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, crematian, or removal, and in any event within 72 haurs after death. TO FUNERAL DIRECTORS Should be derign

ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after of

eath. Page 4

TO HOSPITAL OR VS A15 (4) 15M 10/57



VS A15 (4) 15M 10/57 I

1.1

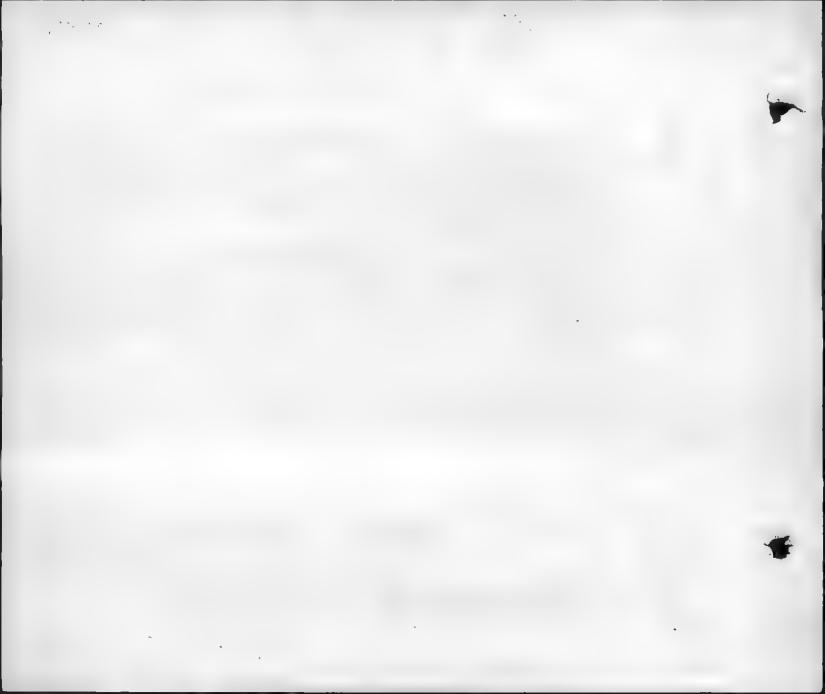
MARYLAND STATE DEPARTMENT	OF HEALTH—BALTIMORE,	18
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**CERTIFICATE OF DEATH** 

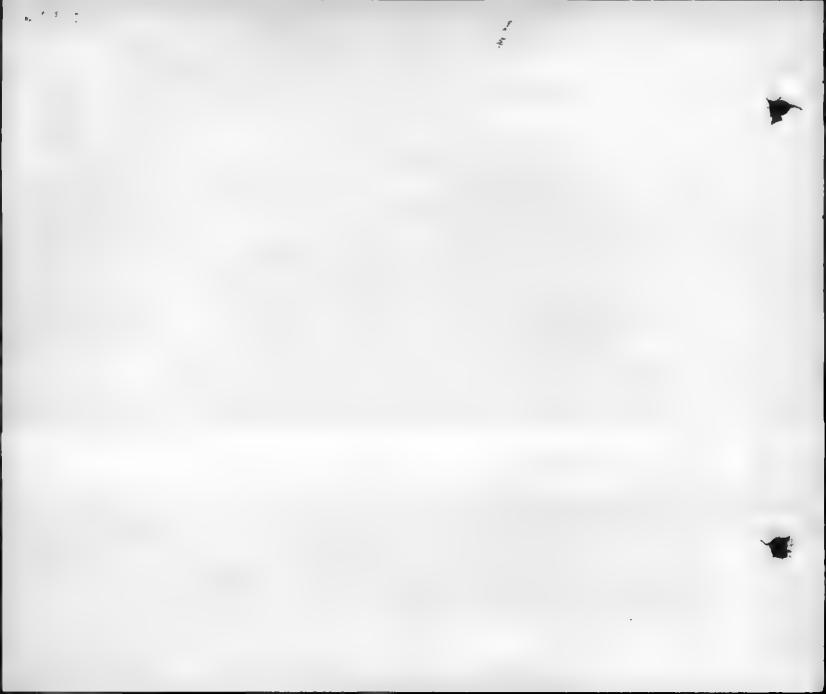
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	7285	CLKIIIIC	AIL OF DEATH	1	Reg. Dist. No.
PLACE OF DEATH W1	comico	MARYLAND	2 USUAL RESIDENCE (WA	ere deceased lived. If institute  Land b county	Residence before odmiss on) WICOMICO
b. CITY OR TOWN (If outs RURAL and give neares),	de corporate limits, write	c. LENGTH OF STAY IN 16		ulside corporate limits, write R Sbury	URAL and give nearest lawn)
d. NAME OF HOSPITAL (IF	not in hospitol, give street of Walnut St	ddress)	d STREET ADDRESS 200	Walnut	e. IS RESIDENCE ON A FARM? YES NO N
3. NAME OF DECEASED (Type or print)	CLARA	MELSTEAD	HUGHES	4. DATE Mon	
Female Wi	olor or race 7 MARRI 11te WIDOWE	DIVORCED	B. DATE OF BIRTH  July 2,188	4 Just birthday)	Mopths Days Hours Min
100. USUAL OCCUPATION (G during most of working li HOUSE WORK	ive kind of work dane 10b 1 le, even if retired)	(IND OF BUSINESS OR INDU	Portsmou		U S A
13. FATHER'S NAME  Cread F. Me.			14. MOTHER'S MAIDEN N Ruhama I	rwin	
15. WAS DECEASED EVER IN 1 (Yes, no or unknown) III yes.	J S ARMED FORCES? 16. 5 give war or dates of service)	OCIAL SECURITY NO. 17. I	John G. Hug Salisbury	hes(Husband ,Maryland	7200 Walnut St.
Conditions, if any, we gove rise to immed cause (a), storing the uritying cause lost.  Past II. OTHER SI  20a ACCIDENT WAS UN OR CONTRIBUTING [ ] C.	DUE TO  (c)  GNIFICANT CONDITIONS CO	ONTRIBLTING TO DEATH BUT			EN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? YES NO
PART II. OTHER SI	CAL EXAMINER)	JURY OCCURRED 20e. PL Not while for	ACE OF INJURY (Home, farm, tory, street, office bldg , etc.	20f. (City or town)	(County) (State)
21. I certify that I alive an	entended the decease	I, and that death	occurred at		70/Jan./9 /19
220. BURIAL, CREMATION, 2		22c NAME OF CEMETERY O Meltower	R CREMATORY	22d. LOCATION (City, town, of Granville, I	or county) (State)
23. FUNERAL DIRECTOR'S SIGN	NATURE	ADDRESS		BY REGISTRAR 24b. REGIS	TRAT'S SIGNATURE





1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	1287 CERTIFICATE OF DEATH  Reg. Dist. No.
Poge 4	1. PLACE OF DEATH  o. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceosed lived If institution Residence before odm ssion).  b. COUNTY  b. COUNTY
the field the fi	b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY, OR TOWN (If, dutside corporate limits, write RURAL and give nearest town)
by the	d. NAME OF HOSPITAL (If you in hospital, give street address)  OR INSTITUTION  ON A FARM?  YES A NO
24 hour	3 NAME OF First A Myddle Lost 4. DATE Month Doy Year OF DEATH JON LOW Y S- 19 500
within prety fill Page	5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH P AGE (In years IFUNDER LYEAR IF UNDER 24 HRS lost bethday) Months Days Hours Min.
d completed completed completed completed control cont	110a USDAL OCCUPAT ON (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. 8 RTHPLACE (State or foreign country)  The state of working life, even if retired)  A Mark 11. A RTHPLACE (State or foreign country)  The state of working life, even if retired)
ate be e carbon on s offer d	13 FATHER'S NAME  14 MOTHER'S MAIDEN NAME  Charlotte Cooper
ng physic remove 72 haur	(15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (If yes, give wor or dolum of services) 220-12-1737 No VISIT OITHERT (If yes, give wor or dolum of services) 220-12-1737 No VISIT OITHERT (IT TO ADDRESS
hat the death y the attend Then pleas event within	PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  INTERVAL BETWEEN ONSET AND DEATH
on. signed by it permit in permit and in ony	Conditions, if any, which gove rise to immediate couse [o], stoting the under- lying cause last.  (c)
ng physicia e has been burial-tran remaval, a	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?  YES NO DECEMBER 19. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10
r Sician pr attendi certificat de as the la atian, ar	UR CONTRIBUTING II CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]  5 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20c. PLACE OF INJURY (Home, farm, 120f (City or town) (County) (State)
MAC PH Note this following the sed for us	Hour a. m. p. m.  19 While at work at while at work 19 to 19 While at work 19 to 19 While at work 19 While a
R ATTEND d by the terminal to be deviced.	alive an
retaine RAL Dis should l	PHYSICIAN'S LAME (Type)
moy be o FUNER page 3 sthe regist	220 BURIAL, CREMATION, 22b. DATE THEREOF 22c, NAME OF CEMETERY OF CREMATORY 22d LOCATION (City, Town, or county) (Store) 22d LOCATION (City, Town, or county) (Store) 22d LOCATION (City, Town, or county) (Store)
VS A15 (4) 15M 10/57	23/FUNERAL DIRECTOR'S SIGNATURE Le my 1/2/talten Poremoke Cety, Md. DATESTAN 3 3/16



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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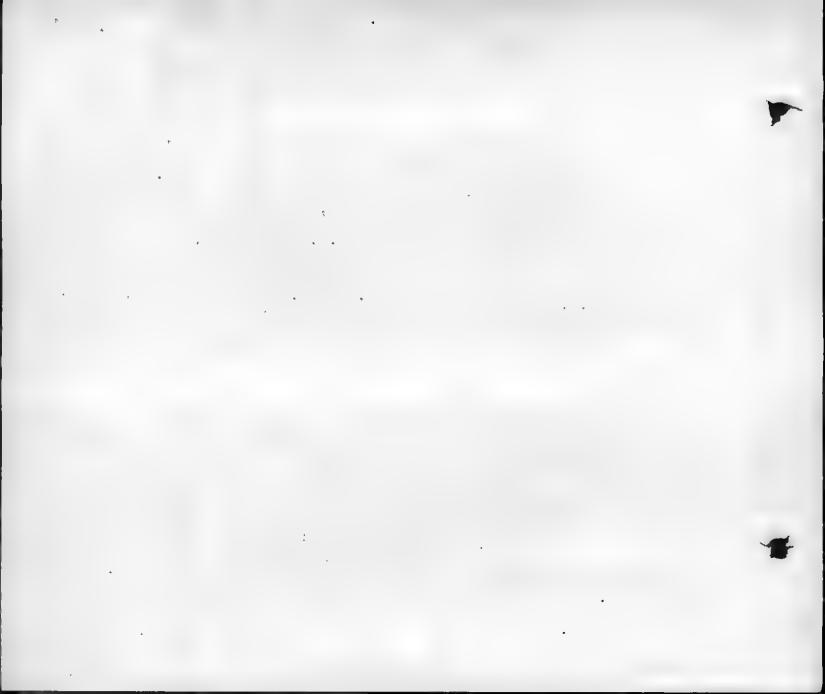
B. CITY OR TOWN If outside corporate limits, write RURAL and give necessify them?  RURAL and give necessify them?  Salisbury  A. NAME OF HOSSITAL If them?  A. STREET ADDRESS  A. DATE  OF ADATE  OF ADA	O THE O	Reg. Dist. No.		EATH	ATE OF [	CERTIFICA	1288	1		<u>"</u> _
RURAL ord give negati Rymy Salisbury  d. NAME OF HOSFITAL III not in hospital, give street address) OR INSTITUTION 421 Hastings St  2. NAME OF HOSFITAL III not in hospital, give street address) OR INSTITUTION 421 Hastings St  2. NAME OF HOSFITAL III not in hospital, give street address) OR INSTITUTION 421 Hastings St  2. NAME OF HOSFITAL III not in hospital, give street address) OR INSTITUTION 421 Hastings St  3. NAME OF HOSFITAL III not in hospital give street address) OR INSTITUTION 421 Hastings St  4. DATE Mannih Do BEATH JAN. 10th DEATH JAN. 10th SEATH JAN. 10th S						MARYLAND	0	Wicomic		1
OR INSTITUTION 421 Hastings St  3. NAME OF OFTEN DECRASED (Type or print)  1. INWOOD LELAND MADDOX  S. SEX Male White Widows Downer Marrierd Divorced May 9, 1897  100. USUAL OCCUPATION (Give kind of work done 100. KIND OF BUSINESS OR INDUSTRY III. BIRTHFLACE (Stote or foreign country) of working life, even furthered the print of the prin	arest town)	e RURAL and give nearest				c. LENGTH OF STAY IN 16	limits, write	outside carparate l'acest towa! 59118bu	b. CITY OR TOWN (III RURAL and give ne	
DECEASED  DECEASED  DECEASED  DIANNOCED  LELAND  MADDOX  DEATH  JAN's  LOTE  S. SEX    6. COLOR OR RACE   7. MARRIED   10. DEVER MARRIED   10. DATE OF BIRTH   10. DEVER MARRIED   10. DEVER MARRIED   10. DATE OF BIRTH   10. DEVER MARRIED   10. DEVER MARRIED   10. DATE OF BIRTH   10. DEVER MARRIED   10. DEVER MARRIED MARRI	e. IS RES DENCE ON A FARM? YES NO		stings St.							,
Male White widowed over the provided of the pr			OF TABI					LIN	DECEASED	3.
The control of working the even trefered by Laborer    14. Mothers Maiden Name   15. Mass Deceased Form   16. Social Security No   17. Informany   17. Informa	IF UNDER 24 HRS Haurs Min	Months Days He	last-by-hday)	897			1			5.
18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (o)  DUE TO  Conditions, if any, which gove rise to immediate couse (o), stating the under lying cause lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 1  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 1  OR CONTRIBUTING   CAUSE OF DEATH   (IF EITHER, NOTIFY MEDICAL EXAMINER)   200. DESCRIBE HOW INJURY OCCURRED   200. PLACE OF INJURY (Home, form, 201. (City or town)   (County)    Haur a. m.	S A		isbury, Md	# Sal:	R.D		ired)	no life, even it reli-	mployee_S	E
18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b)  DUE TO  Conditions, if any, which gove rise to immediate couse (a), storing the under lying cause (ast.)  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1  20a ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING [2] CONTRIBUTING [2] CONTRIBUTING [3] CONTRIBUTING [4] CONTRIBUTING [5] CONTRIBUTING [6] CONTRIBUTION [6] CONT	ings St	ማଅl Hasti:	dox(Wife)4	M. Mado	NFORMANT 'S Lena	SOCIAL SECURITY NO IZ		të yes, give wor or dates	WAS DECEASED EVER	15
20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While Nol while of work 19 While Nol while of work 19 Nol w	19 WAS AUTOPSY PERFORMED?	GIVEN IN PART HO) 19 )	elgna DISEASE CONDITION GIV	HE TERMINAL L	NOT RELATED TO	Sygus Te	(b) (c)	DUE ny, which nmediate the under-	Canditions, if or gove rise to an cause (a), stating t lying cause last.	NOE
21. I certify that I attended the deceased from	YES NO TX		or Part It of item 18.)	injury in Part I	D (Enter nature a	CRIBE HOW INJURY OCCURRE	TH 206 DESC	S UNDERLYING TO CAUSE OF DEAT	200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	CERTHICA
alive an	(State)	(County)	f. (City or town)	ome, form, 20 oldg., etc.)	ACE OF INJURY (	Nal while fa	While	· ·	20c. TIME OF INJURY Have a. m. p. m.	MEDICAL
SIGNATURE ALL Shy Wif Jan J. M.D. Mich. Contr. Shy Wif Jan J.	2									
PHYSICIAN'S Dr. William Smith Salishury Ma	DATE SIGNED 12 /195	0- 10	-00 8	Cute.	M.O. Miles	with	3	14	ACTUAL	
	ryland	sbury, Mar		22.1	D COEMATORY				NAME (Type) DI	22
220. BURIAL CREMATION. 27b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY NEMOYAL (Specify) Jan. 12, 1959 Union Cemetery Near Salisbury, Mar 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240 RECUBER AND REGISTRAR'S SIGNATURE		sbury, Mary	ear Salisb	N		Union Ceme		Jan.12	REMOVAL (Specify)	

VS A15 (4) 15M 10/57

HOLLOWAY & COMPAIX

SALISBURY MARYLAND 240 REC'D BY REGISTRAR

246. REGISTRAR'S SIGNATURE



Royer, M.D

ADDRESS

22c. WAME OF CEMETERY OR CREMATORY

220 BURIAL CREMATION, 226 DATE THEREOF

REMOVAL (Specify)

23. FLINERAL DUÉCTOR'S SIGNATURE

designated should be if FUNERAL D 70 VS. A15ME 5M 2137

24o. REC'D BY REGISTRAR

22d LOCATION (City, town,

24b. REGISTRAR'S SIGNATURE

(County)

Wicomico

Doys

Hours

12 CITIZEN OF WHAT COUNTRY?

INTERVAL SETWERN ONSET AND DEATH

Sudden

PERFORMED?

(Stole)

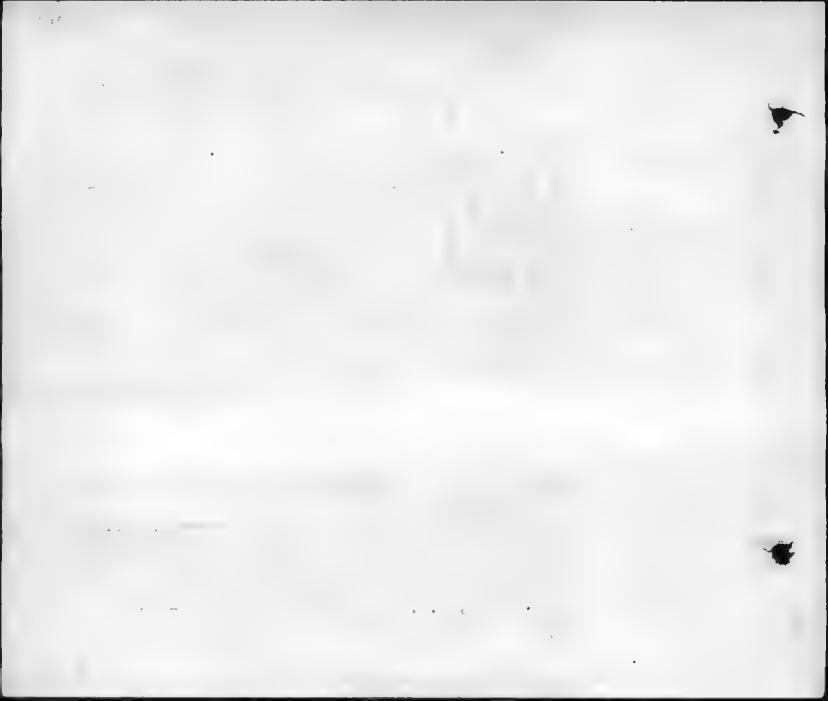
and in my

DATE SIGNED

(Stote)

e IS RESIE THE E ON A FARM?

YES NO



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



VS A15 (4) 15M 10/57

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1	RI	i
P		$\mathcal{I}$

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01301

120: CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY	icomico		MARYLAND	2 USUAL RESIDENCE (W		b. COUNTY		e before odmis	sion)
6 CITY OR TOWN (	If outside carporate lim	ls, write	c. LENGTH OF STAY IN 16	J.		prote limits, write RI			n)
RURAL ond give n	eorest town) SDUTY		877 days	West					-
d. NAME OF HOSPI	TAL (If not in hospital, )	ive street		d STREET ADDRESS			y <sub>2</sub> _ h	e IS RES	SIDENCE
OR INSTITUTION Deer 's	Head State	Hosp	ital	RD #	1				PARM?
3. NAME OF DECEASED	Fil	••	Middle	Lost	4. DATE	Mon	th	Day	Yeor
(Type or print)	Mar	7"	Cathari		DEATH				19 59
5. SEX		7 MARI	RIED   NEVER MARRIED	B. DATE OF BIRTH		9. AGE (In years lost birthday)		YEAR IF UND	
Female	White	WIDOW		June 27, 18		92 yrs.	monins	Pays Hours	Min.
10a. USUAL OCCUPATION during most of wor	ON (Give kind of work king life, even if retired	done 10b	KIND OF BUSINESS OR IND	USTRY 11 BIRTHPLACE (Stot	e or foreign c	ountry)	12 CITIZ	EN OF WHAT	COUNTRY
				Revels	Neck			U.S.A.	
13. FATHER'S NAME				14 MOTHER'S MAIDEN	NAME				
Samuel	James Nels	on		Mary 1	Bozman				
15. WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY NO. 17.	INFORMANT		Addr	ess		
(Yes no, or unknown)	(1) 10 210 10 10 10 10 10 10 10 10 10 10 10 10 1		217-36-0016	Hospital Re	ecords	, Salisbu	ry, M	aryland	
		use per li	ne for (o), (b), and (c) ]			~		INTERVAL BE	TWEEN
PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (c	Ar	terioscleroti	c cardiovascu	lar di	sease		Year	S DEATH
LL d. 0 1	· ·								
Conditions, if a	ny, which ) (b	Ar	teriosclerosi	s generalized				Years	
gove rise to i	mmediate (	,							
lying cause lost.	) Ic	)							
PART II. OT				T NOT RELATED TO THE TERA	MINAL DISEAS	E CONDITION GIV	EN IN PART	1(o) 19 WAS	AUTOPSY
2	Diab	etes	mellitus						NO K
	S UNDERLYING A CAUSE OF DEATH MEDICAL EXAMINER)	20b DES	CRIBE HOW INJURY OCCURR	RED (Enter nature of injury in	Port I or Par	t II of item 18.)			
	Y Month, Day, Ye	or 20d. II	NJURY OCCURRED 20e. I	PLACE OF INJURY (Home, for	m, 20f. (Cit)	r or town)	ICe	uniy)	(State)
Hour o.m	19	While of wor	Not while	octory, street, office bldg., et	c.)		·		
	-411 -444-4 -4			10 FG .	Tom	22 50			
alive on Ja		deceds	ed from Buga 67.	, 19.56, 1a	<u> </u>	62, 19.27	.,that I Ia	ist saw the	deceased
alive on THE	114-67	, 19	$27_{-}$ , and that deal	th occurred at \$325	A_M, frai	m the causes a	nd on the		
ACTUAL	VVI	1	1.1.	T) 1 - TT		treet, city or town,		7 10	ATE SIGNED
SIGNATURE	V	ريار	any .	M.D. Deer's He	ead St	ate Hospi	tal	7/2	3/59_
PHYSICIAN'S NAME (Type)	L. V.	Mald	ve, M. D.	Salisbur	y, Mar	yland	÷======		
270. BURIAL, CREMATIC SEMOVAL (Spec fy)	1 - 2 >	(/	22c NAME OF CEMPTER	Cemiles	1/1/-	TION (City, town, o	Prounty)	1 Stat	id
23 FUNERAL DIRECTOR	S SIGNATURE,	1	ADDRESS	740 REC	D BY REGIST	TRAR 24b REGIS	TRAR'S SIGN	NATURE	-
Journ	Malson	10	meso ()	molista	N 2 7 '5	9 , , ,	ho 2 da		



20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH 20c TIME OF INJURY Hour o. m.

alive on ACTUAL SIGNATURE

NAME OF

5 SEX

DECEASED

(Type or print)

no

220. BURIAL, CREMATION, 23. FUNERAL DIRECTOR'S

DATE THEREOF

22c, NAME OF CEMETER

**ADDRESS** 

24d REC'D BY REGISTRAR

246. REGISTRAR'S SIGNATURE 8. Frank (Stole)

224 tOCATION (City, lown, or county)

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	260	2 021(11110	716	, DEAII			Reg. Di	ist. No.	_	
1. PLACE o. COL	of death INTY Wicomico	MARYLAND	2. USU/ 6 ST	AL RESIDENCE (WHATE Maryla		b. COUNTY	on Reside			s on)
b. CITY	OR TOWN (If outside corporate limits, write AL and give nearest town)	c. LENGTH OF STAY IN 15	c. CI	TY OR TOWN (If a	outside corpo	rote limits, write R	URAL ond	give nea	rest fow	n)
1.	alistury	74 days		Denton		2	, of			1
OR .	AE OF HOSPITAL (If not in hospitol, give street ASTITUTION Der's Head State Hospi		d. 5	REET ADDRESS					ON A	SIDENCE A FARM?
3. NAME DECEA (Type o	SED T.3.	Middle Mae		lo: Morgan	4. DATE OF DEATH	Janua		16		Yeor 1959
5. SEX	emale 6. COLOR OR RACE 7. MARK	TIED NEVER MARRIED DIVORCED DIVORCED	8 DATE 0	25/1876		9 AGE (in years lost birthdoy) 2 yrs	Months	Days	Hours	ER 24 HRS Min
OUTIN	LOCCUPATION (Give kind of work done 10b phost of working life, even if retired)	KIND OF BUSINESS OR INDI	USTRY 11.	Maryland		ountry)		TIZEN O	f WHAT	COUNTRY
13. FATHE			14. MC	THER'S MAIDEN N						
Ja	mes Trice				Adki	ns				
15. WAS E	DECEASED EVER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO 17	INFORMA	™ Hospita	al Rec	ords Add	ress			
18. C	AUSE OF DEATH [Enter only one couse per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) GE	ne for (o). (b). ond (c) ] neralized care	cinoma	itosi <b>s</b>					RVAL BE	ETWEEN DEATH
Con		. of Cervix							?	
cous	e rise to immediate DUE TO couse last.									
CATION	PART II. OTHER SIGNIFICANT CONDITIONS O	ONTRIBUTING TO DEATH BU	T NOT RELA	TED TO THE TERMI	NAL DISEAS	E CONDITION GIV	EN IN PAR	?T 1(o) 1!	PERFO	AUTOPSY ORMED?
OR CO	CCIDENT WAS UNDERLYING (20b. DESC DNTR BUTING (CAUSE OF DEATH HER, NOTIFY MEDICAL EXAMINER)	ERIBE HOW INJURY OCCURR	ED. (Enter n	oture of injury in F	Port 1 or Part	t (I of item 18 )				
~	ME OF INJURY Month, Doy, Year 20d. II Hour e. m. 19 While p. m. 19	Not while for	LACE OF IN	URY (Home, form t, office bldg., etc.	20f (City	er lawn)	(	County)		(Stote)
21. [	certify that I attended the deceas			9 <u>58</u> , taJ	Jan. 1	6 , 1959	"that I	last sa	w the	decease
alive	on Jan. 16 195	2, and that deat	h occurre					he dat	e state	ed abav
ACTU/ SIGN/	AL VIOLE VIOL	ha	.M.D			reet, city or town, ate Hospi		1/	16/5	ATE SIGNE
	CIAN'S L. V. Maldve, M	I. D.		Salis bury	, Mar	yland				
200 श्रीकार स्टिक्ट	L. CREMATION 226. DATE THEREOF	NAME OF CEMETERY	OR CREMAT	ORY	/	MICHYPTOWN,	or county)		10/0	
73. FUNER	AL DIRECTOR'S SHOWATURE	ADDRESS ( )	1-1	PATE JA	D BY REGIST		TRAR'S SI			1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the haspital or attending physician.

TO FUNERAL DIRECT After this certificate has been signed by the attending physician and completely filled in by the page 3 should be adjached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shout the registrar prior to burial, cremation, or removal, and in any event within 72 haurs offer-death.

VS A15 (4) 15M 10/57

of director,



VS A15 (4) 1/ 15M 10/57 M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01305

1295 CERTIFICATE OF DEATH

Rea.	Dilan.	MI-
ACC.	LIFTS F.	FIG.

			7 × 2 7		110	311 7101
1	1 (	PLACE OF DEATH	MARYLAND	2. USUAL RESIDENCE (Where dece	eased I ved. If institution Resider	ice before admission)
1		b. CITY OR TOWN (If outside corporate limits, write	c. LENGTH OF STAY IN 16	IMEGIAI	WA WIC	Junito .
		RURAL and give nearest town)	C. SENGTH OF STAT IN 18	C OTT OR TOWN IT DUSING CO	orporate limits, write RURAL and	give nearest town)
	H	d NAME OF HOSPITAL (If ript in hospital, give street	address)	d STREET ADDRESS		e IS RESIDENCE
and a		DR INSTITUTION	11 1	1211 511-1	1()	ON A FARM?
	1	NAME OF FIRST	Middle	310 C-1161)	<u> </u>	YES NO IX
	1	Type or print) LANGON	Milosia	OF.		By Year
	5. 5	6 COLOR OR RACE 7. MARR	HED NEVER MARRIED	B. DATE OF BIRTH		TYEAR IF UNDER 24 HRS
		male (6). WIDOWE		2-15-1881	Ost birthday  Months	Days Hours Min
1	10a	USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stole or foreign	gn country) 12. CII	TIZEN OF WHAT COUNTRY
	12	Chool Patrol gayed Ci	ty 6005	- MAIZULANO		U.SA.
/	13	FATHER'S NAME		14. MOTHER'S MAIDEN NAME	1 1	
	L	HIEXANDER IVIC	PRIS	CIARA	HENRY	
		WAS DECEASED EVER IN U.S. ARMED FORCES? 16.	SOCIAL SECURITY NO 17 II	NFORMANT	Address	FILEU S+
		20	14-10-8883 711	RS, DIARGIARET	Kimble, SAI	Shuzy Md
		18. CAUSE OF DEATH [Enter only one couse per lin	ne for (a), (b), and (c) ]	1 2 4 1		INTERVAL SETWEEN
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	entro Vasc	ule accessent		ONSET AND DEATH
		DUE TO	. 11	1 ~ 1 _		
		Conditions, if ony, which   (b) (b)	Abrolate	a morile	tw	
		couse (a), stating the under-		/		
	7	lying couse lost. } (c)				
7	OIT	PART II OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DIS	EASE CONDITION GIVEN IN PAR	T I(a) 19 WAS AUTOPSY PERFORMED?
	FICA	20g ACCIDENT WAS UNDERLYING 20b. DESC	"DIDE LACLE IN LUMB OF CHANGE			YES NO
	L CERTIFICATION	OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	THISE HOW INJUST OCCURRE	D. (Enter nature of injury in Port t ar	Part II at stem 18.)	
	MEDICAL			CE OF INJURY (Home, form, 20/ ( tory, street, office bldg., etc.)	[City or town] [6	County) (State)
	MEC	p. m. 19 While of work		7	1	
		21. I certify that I pttended the decease	ed from //30/-	59, 19 to 1 31	/ / 5 / 9 that 1	last saw the deceased
		alive an 1/3/54 19	, and that death	occurred at 3 3/2 M, fi		
		Mi a Drank	1:11	ABORESS	\$ (Street, city or down, state)	DATE, SIGNED
,		ACTUAL SIGNATURE MUTU	hell	4.0. 24 Minskerd	Salishing	me 1/3/1/0
/		PHYSICIAN'S O A A O LC	1 - 11		,	1
		NAME (Type) 17, L. M/1+(	<u> </u>			
	220	BURIAL, CREMAT ON, 22b. DATE THEREOF	ZZc NAME OF CEMETERY O	CREMATORY 22d LO	CATION (City town, or county)	(State)
		SURIA 12-4-59	GREEN HORE	MEMORIAL BOK -	Alisbury	ms
	73	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REC	GISTRAR 246, REGISTRAR'S SIG	SNATURE
	١,	F, STEWART FLINERAL HON	nF- 27/1304	RU MA PARE 8 159	1	Art





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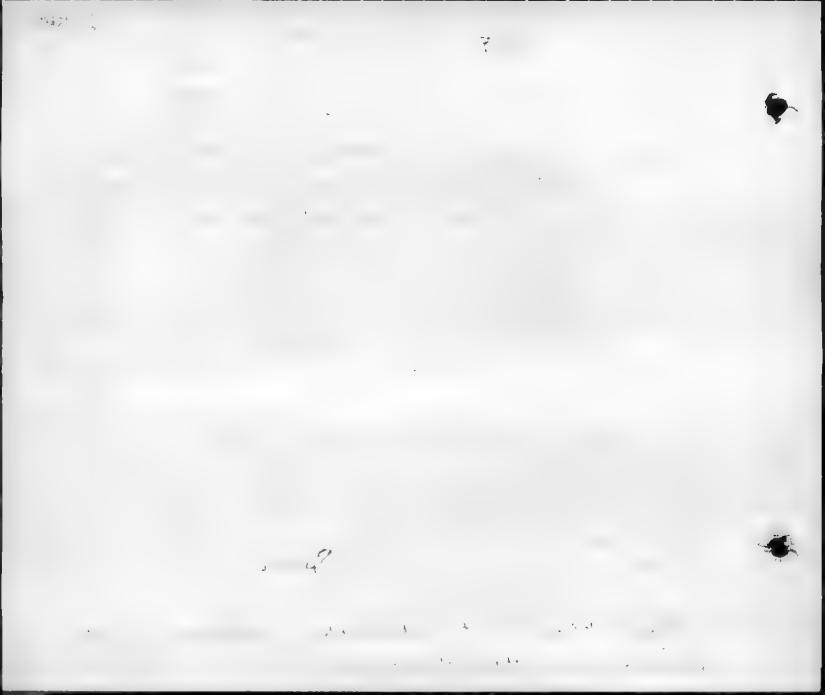
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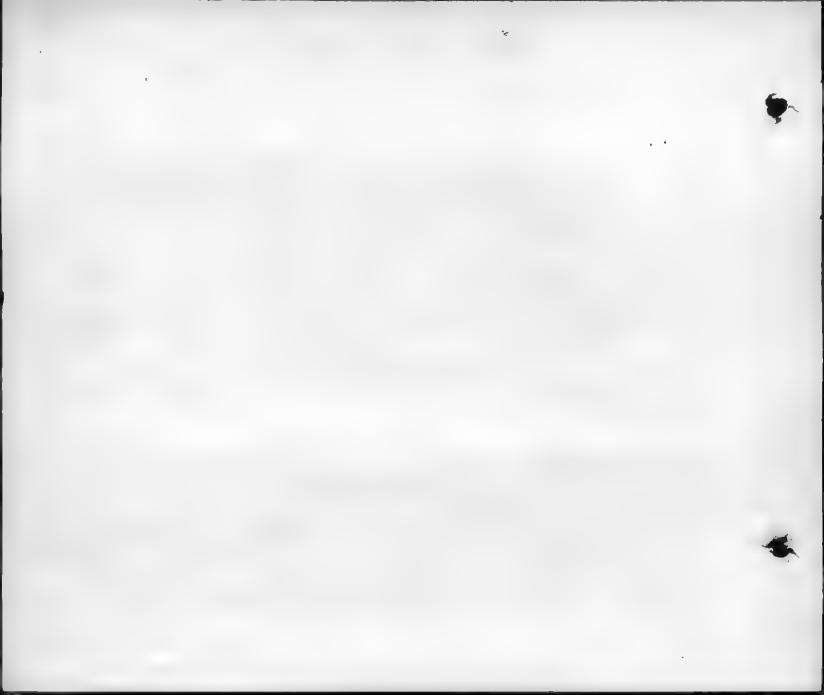


1297 CERTIF	FICATE OF DEATH R.	g. Dist. No.
1. PLACE OF DEATH O. COUNTY  MARYLA	AND  2. USUAL RESIDENCE (Where deceased lived. If institution R b. COUNTY b. COUNTY	esidence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	N 1b c. CITY OR TOWN (If/autside corporate limits, write RURAL	and give nearest town)
d. NAME OF HOSPITAL (Final) in haspital, give street address?  OR INSTITUTION  OR INSTITUTION  OR INSTITUTION  OR INSTITUTION	d STREET ADDRESS	e is residence on a farm? Yes [7] no [
3 NAME OF DECEASED (Type or print)  First Middle	Losi 4. DATE Month Of DEATH January	
S. SEX  6 COLOR OR RACE   7 MARRIED   NEVER MARRIED  NEVER MARRIED   DIVORCED	lost birthdoy) Mo	NDER YEAR IF UNDER 24 HRS nihs Doys Hours Min.
100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR during most of working life, even if retired)	Maryland	2. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME  15. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. If yes, given wer or dates of service?	14 MOTHER'S MAIDEN NAME  17. INFORMANT  Address	
1B CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY	1 0 1 0 1	INTERVAL BETWEEN
HAMEDIATE CAUSE (a)  420.0  Conditions, if any, which gave rise to immediate couse (a), stating the under.		7 day,
3 POLICIAL DASOVIAL DISCHIBE HOW INJURY OCC	TH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN II	N PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO
	20e. PLACE OF INJURY Hame, form, 20f. (City or town) factory, street, office bldg., etc.)	(County) (State)
21. I certify that I attended the deceased fram	death accurred at 1212, M, from the causes and ADDRESS (Street, city or town, state)  Mo. Salisbury Md.	an the date stated above
NAME (Type)  270. BURIAL, CREMATION, 22b DATE THEREOF 27c NAME OF CEMETI SUR'S 1 1 22 - 57 St. MARK  23. FUNERAL DIRECTOR'S SIGNATURE APPRESS	KS CEMETERY ROCKAWAIKIN	1 md
LE Stomat Kingson Hans Palan	24. REC'D BY REGISTRAR 246 REGISTRAN	and the second s

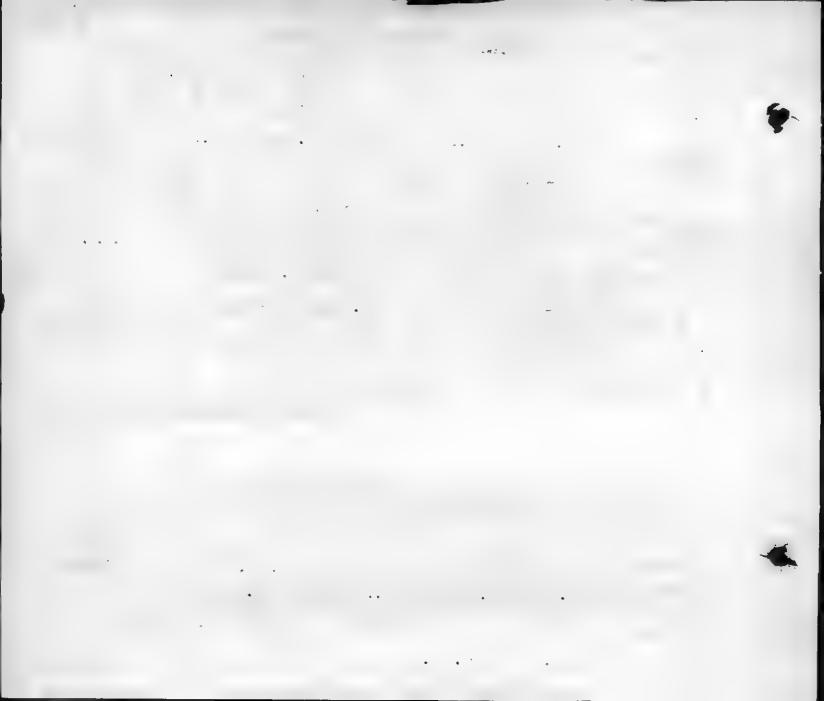
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital ar attending physician.

TO FUNERAL DIRECT. After this certificate has been signed by the attending physician and campletely filled in by the placetar, page 3 should be defected for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shours effiled with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death. VS A1S (4) 15M 10/S7





	П		MARYL	AND.	STATE DEPARTM	NENT OF I	HEALIF	1—BALTIN	NORE, 18		043	309
_ ~ \	L		7.9	AP	CERTIFIC	ATE OF	DEATH	-		Reg. Dist. No	11 20 1	909
filed will	1	PLACE OF DEATH a. COUNTY Wicom			MARYLAND	o STATE	yland	here deceased live	b. COUNTY	ico		
20		RURAL and give ne			c. LENGTH OF STAY IN 16	100		outside carporate l	imits, write RUF	IAI, and give ne	arest lawn	) -
/ 1		d. NAME OF HOSPIT. OR INSTITUTION	a <b>lisbury</b> AL (If not in hospito), g	ive street	oddress)	d STREET					e. IS RESI ON A	DENCE FARM?
r r			112 E. W13	Lliam	St.,	122	E. Wi	lliam St	, , ,		YES [	NO M
	3	NAME OF DECEASED (Type or print)	fin	ad	Middle	Lo To		4. DATE OF DEATH	Month	De		1601 1959
	5.	SEX	6. COLOR OR RACE	7. MARE	Parsons RIED NEVER MARRIED	Parke:		9. A	GE (In years III	UNDER I YEAR		
		Female.		WIDOW		Apr 21		79		Months Days	Hours	Min.
/ ` \	10	during most of work	N (Give kind of work ding life, even if retired)	fone 10b.	KIND OF BUSINESS OR INDE	STRY 11. BIRTHP	LACE (State	or foreign country	r)	12. CITIZEN C	OF WHAT	COUNTRY?
	1	FATHER'S NAME			Own Home	Mar 14 MOTHER	vland			J U.S.	Α.	
	13.		- *									
		WAS DECEASEDEVE	rner PArsor	CES? 16	SOCIAL SECURITY NO 17	Marti Informant	FIRE Co.	Wimbrow	Addres	\$		
4	I I	n. no. ar unknown)	If yes, give wer or dotes of se		lone	Wrs. Ire	ne Tod	d- Same				
					ne for (a), (b), and (c).]		2	0		INT	ERVAL BET	TWEEN
		PART I. DEAT	TH WAS CAUSED BY: IMMEDIATE CAUSE (o)	St	Unio seleto	Ge He	ret	Veseus	le	7	un	
	П	4 . 1	DUE TO		ŕ						1	
		Canditions, if or gave rise to in	nmediate									
		cause (a), stating I lying cause last,	the under DUE TO									
		PART II. OTH			CONTRIBUTING TO DEATH BU	T NOT RELATED TO	O THE TERMI	INAL DISEASE CO	NDITION GIVEN	I IN PART 1(o)	19. WAS A	AUTOPSY
71	S											NO 🔲
	1 CERTIFICATION		MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURR	D (Enter noture o	of injury in I	Part I or Part II of	item 18.)			
	MEDICAL	Hour p. m.	f Month, Day, Yea 19	While		LACE OF INJURY ectory, street, offic	(Hame, form to bldg., etc.	. 20f (City or to	wn)	(County)		(Stote)
			at Lattended the	deceas	ed from	. 19,50	, ta	119	1958	that I last s	ow the	decensed
		alive an 1/2	1/5-9	12_	and that deat		6.12		e causes an	d an the do	ite state	
		ACTUAL SIGNATURE	Texal A.	14	ramse	M.D. Sali				1,	/9/59	
i /		PHYSICIAN'S NAME (Type)	red R. Gra	nse S	S. Division St	Salis	bury,	Md.				******
n n		REMOVAL (Specify)	10/59	F	22c. NAME OF CEMETERY C			Saisbur	(City town, or Mary	county)	(Stote	:)
	23	FUNERAL DIRECTOR	SIGNATURE		ADDRESS			D BY REGISTRAR	24b REGISTI	AR S SIGNATU	RE	
		Hill & Joh			oury. Md.		DATE	N 1 2 '59	Ciri	. M. S. 9 Cra	Max	
		no	mon9/	Bal	WA /							



MARILA	IND STATE DEPARTM		LIIMOKE, 16	01310
	300 CERTIFICA	ATE OF DEATH	Re	g. Dist. No.
1. PLACE OF DEATH  COUNTY  WICOMICO	MARYLAND	2 USUAL RESIDENCE (Where decer	b. COUNTY	Residence before admission)
b CITY OR TOWN (If outside corporate limits, v RURAL and give nearest town)		c. CITY OR TOWN (If autside co		L and give nearest town)
d. NAME OF HOSPITAL III not in holpitol, give OR INSTITUTION C. NERA	L HOSPITAL	302 EAST	STREE	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECRASED First RA	NK S.	PARSONS 4. DAT		Day Year 2 1959
MALE WHITE W	DOWED DIVORCED	B. Date of Birth July 27,1921	lost birthdoy] Me	NOTER I YEAR IF JNDER 24 HRS. Onths Days Hours Min
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	Plumbing	Delmar, Mary		U S A
Ruben Parsons		Cora Mae Smi	th	
15 WAS DECEASED EVER IN U. S. ARMED FORCES [Yes no or pohnown] [1) yes, give war or date of service	16. SOCIAL SECURITY NO. 17	s Julia Parsons Delmar Mary	WWife) 302	East St.
1B. CAUSE OF DEATH [Enter only one couse PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	per line for (o) (b) and (c) ]			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if ony, which gove rise to immediate cause (a), stating the under-lying cause lost.	fabracute /	Slomerukor	replan)	Tis 4 ym
PART II OTHER SIGNIFICANT CONDUCTOR	Thremany.	Tract Ling	ection	N PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO
OR CONTRIBUTING LI CAUSE OF DEATH		D (Enter nature of entury in Part Var I		
3 20c. TIME OF INJURY Month, Day, Year	20d INJURY OCCURRED 20e. PL	ACE OF INJURY IHome, form, 20f. (C	lity or town)	(County) (State)

Hour a.m.

While Not while of work

21. I certify that I attended the deceased from alive an

19\_\_\_\_,that I last saw the deceased

PHYSICIAN'S Dr. Dav 14 Gilmore

Center-

Salisbury

220. BURIAL, CREMATION, 226. DATE THEREOF BURIAL Jan. 5.19

22c. NAME OF CEMETERY OR CREMATORY Mt Olive Cemetery

and that death accurred at  $oldsymbol{\mathcal{L}}$ 

22d. LOCATION (City fown, or county) Delmar Delaware

(State)

DATE SIGNED

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

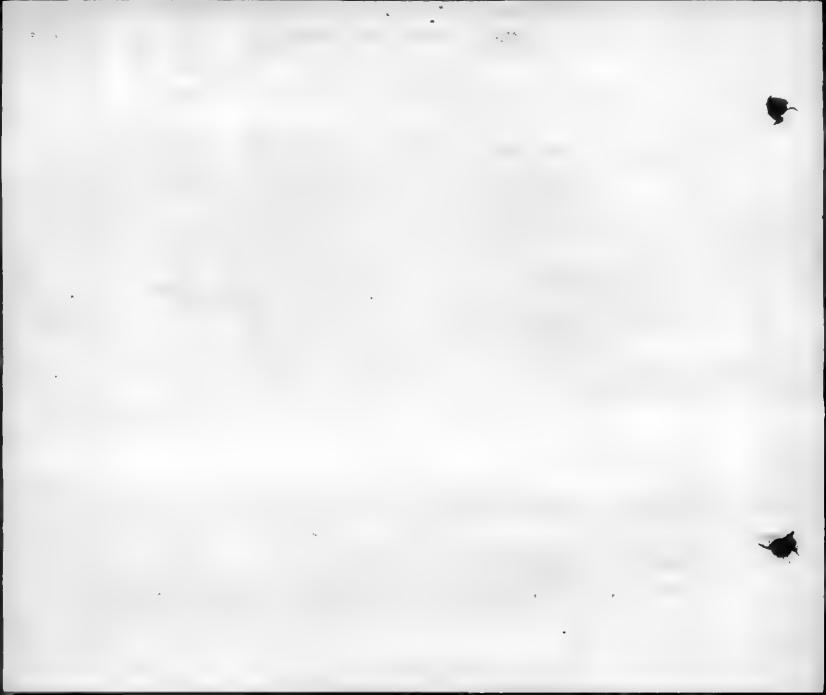
24o. REC'D BY REGISTRAR

246 REGISTRAR'S SIGNATURE

P.M., from the causes and on the date stated above

**VS ATS (4)** HOLIOWAY & COMPANY 15M 10/57

SALISBURY MARYLAND



**CERTIFICATE OF DEATH** 

01311

Reg. Dist. No.

					·							
1. PLACE OF DEATH 6. COUNTY	Wicomico		MARY	LAND	2. USUAL RESIDEN a. STATE	rvla		lived. If institute b. COUNTY		nce before		סר)
b. CITY OR TOWN RURAL and give	(If outside carporate limi	ls, write	c. LENGTH OF STAY	IN 16	c CITY OR TOV	NN (If o	utside corpo	rate limits, write R	URAL and	give near	est town)	V
Sali	sbury		462 day	7S	Sn	ow I	H111		001	A A		
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, g	ive street	oddress)		d. STREET ADD	RESS				0.	IS RESI	
	Head State	Hos	ital		R	.D.	# 2				YES K	NO [
3. NAME OF DECEASED	Fie	st	Middle		Lost		4. DATE OF	Mor	ith	Day	Y	ear
(Type or print)		ver	Raymo		Philli	ps	DEATH	Janua	ry	8	1	9 59
5. SEX	6. COLOR OR RACE	7. MARI	HED NEVER MARRI	ED 🔲	B DATE OF BIRTH			9 AGE (In years		RIYEARI		24 HRS
Male	White	WIDOW	DIVORCE	□□	May 14,	189	91	last birthday) 67 yes.	Months	Days	Hours	Min
100. USUAL OCCUPAT	ON (G ve kind of work	dane 10b.	KIND OF BUSINESS C	R INDU	STRY 11. BIRTHPLAC	E (State	or foreign co	ountry)	12 C	TIZEN OF	WHAT (	COUNTR
Lornig most of wo	rking life, even if retired •••	'			Snow	H11	l. Mar	vland		U.S	.A.	
13. FATHER'S NAME					14. MOTHER'S MA							
Isaac	Bertram Ph	<b>illi</b> 1	os		Mary	Hai	mblin					
15 WAS DECEASED EV (Yes. no. or unknown) Unk No.	ER IN U. S. ARMED FOR (II yes, give wor or dotes of s	CES? 16 ervice)	SOCIAL SECURITY NO	A	or S Head	r R	Phil	lips(Sc	n)R	D.#	Sno	ow H
	ATH Enter only one co	use per lin	ne for (a), (b), and (c)								VAL BET	
	ATH WAS CAUSED BY:	Δ	bdominal c		nomatosis					ONSE	TANDI	DEATH
151X	IMMEDIATE CAUSE (o	)									- 4	
Con Circ		C	arcinoma o	f th	e stomach						?	
Conditions, if	immediate (											
tying couse last.												
_	, 10		CANTOIN ITING TO DE	A TAU DIAT	NOT BELLIED TO TH	IC VC DAAD		*	45.4.4.5.		1445 4 4	
CATI	HER SIGNIFICANT CON								EN IN PA		PERFOR	SMEDS
	AS UNDERLYING [] G [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY O	CCURRE	D (Enter nature af in	jory in I	Part I or Part	II of item 18)				
20c. TIME OF INJU Hour a.m. p. m.	RY Manth, Day, Yes 19	While	NJURY OCCURRED  Not while  at work	20e. PL/ fec	ACE OF INJURY (Hor tary, street, office bl	ne, form dg., elc.	20f. (City	ar town)		(County)		(Stole)
21. I certify tolive on J	_	19_	ed from Oct.	death	occurred at_6	:50.	ADDRESS (SI	the causes o	and an	lost sov	stote	deceose d abov te signe
PHYSICIAN'S NAME (Type)	G. K	osmal	nly, M. D.		Salish		, Mary	land				
220. BURIAL, CREMATION REMOVAL (Specify	Jan. 10,		Mt Oliv		emetery			on (City, town, ester (			(Stole)	
23 FUNERAL DIRECTO	'S SIGNATURE		ADDRESS		24	o REC'I	D BY REGIST	RAR 24b REGI	STRAR'S S	PANYINSE		
HOLLOWAY	& COMPAN	Y	SALISBURY	Z MA	RYLAND	MASSIA	8 .23		W s			

TO MOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be TO FUNERAL DIRECTOR Page 3 should be defect the registrar prior to but **VS A15 (4)** 15M 10/57

After this certificate has been signed by ached for use as the burial-transit permit.



VS A15 (4) 15M 10/57

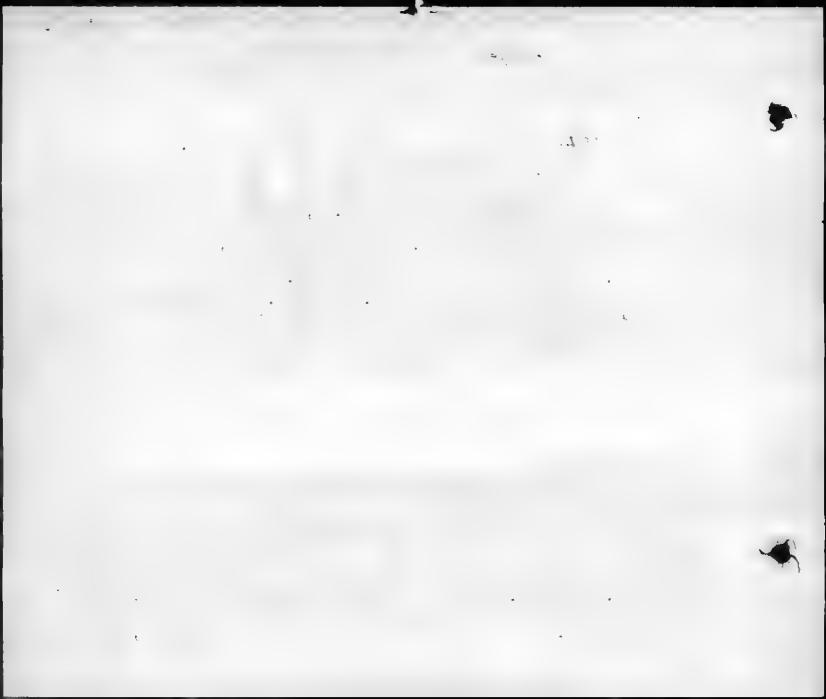
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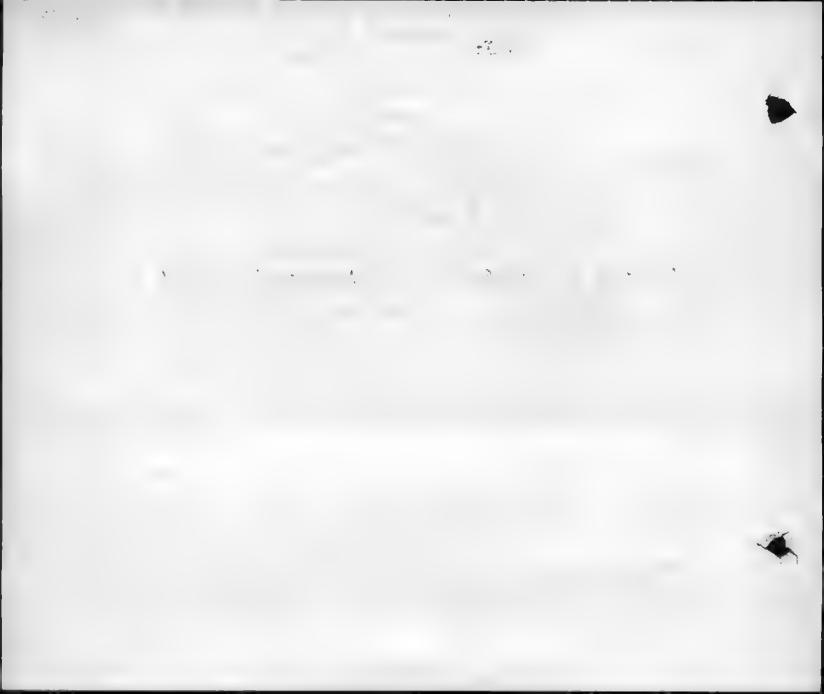
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- U	1	O	T	15

CERTIFICATE OF DEATH  Reg. Dist. No.		
1. PLACE OF DEATH  o. COUNTY  Wi Comico	MARYLAND	2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE Maryland b. COUNTY Wicomico
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Salisbury
or Institution  TENINSULA OFDERAL	Hospital	d. STREET ADDRESS  608 Camden Ave.  o is residence on a farm? yes \( \text{No } \text{NO } \)
3 NAME OF DECRASED (Type or print) ROBERT*	WASHINGTON	REVELLE OF DEATH INWATU 26 1959
Male White widow	PED DIVORCED	Peb.12,1883  PAGE (In years   IF UNDER 1 YEAR IF UNDER 24 HRS   Months   Days   Hours   Min   Mi
	Motor Co.)	Princess Anne, Maryland USA
Sydney F. Revelle		Mary A. Heath
15 WAS DECEASED EVER IN U. S ARMED FORCES? 16 (Yes, no. or unknown) Iff yes, give wor or dates of service)	SOCIAL SECURITY NO Mrs	Salisbury, Maryland Camden Ave
PART II. OTHER SIGNIFICANT CONDITIONS	Arterio. Arterio	INTERVAL BETWEEN ONSET AND DEATH  ONSET AND DEATH  ON THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY
200. ACCIDENT WAS UNDERLYING TO 20b. DES OR CONTRIBUTING CAUSE OF DEATH IT IF THERE, NOTIFY MEDICAL EXAMINER)		(Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d I Hour o. m. While		CE OF INJURY (Home, form, 20f (City or town) (County) (State) cry, street, office bldg , etc.)
21. I certify that I attended the deceased from.  21. I certify that I attended the deceased from.  22. I certify that I attended the deceased from.  23. I certify that I attended the deceased alive on.  25. I		
220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) BUT121 Jan. 29, 195	22c NAME OF CEMETERY OR WICOMICO M	CREMATORY 2d. LOCATION (C ty town, or county) (Stote)  Temorial Park Salisbury, Maryland
23 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY S.	ADDRESS ALISBURY MARY	240. REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE LAND DATE JAN 2. 8 '59





and ofter o 8 physician remove á ë.E å prior 70 IUNERAL ■ 9

PHYSICIAN'S NAME [Type] BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE VS A15 (4) 15M 10/57

1 PLACE OF DEATH

OR INSTITUTION

o COUNTY

NAME OF

DECEASED (Type or print)

13. FATHER'S NAME

lying couse last.

Hour o.m.

alive on

SIGNATURE

**ACTUAL** 

5. SEX

22c NAME OF CEMETERY OR CREMATORY **ADDRESS** 

24o, REC'D BY REGISTRAR DATE JAN

246 REGISTRAR'S SIGNATURE

(State)

or county)

22d. JOCATION (City, town



01315

**CERTIFICATE OF DEATH** Reg. Dist. No. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY 5. COUNTY MARYLAND WILDMICO b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) RURAL and give nearest town) DAYS JALISBURY d NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e IS RES DENCE OR INSTITUTION HOSPITA ENINSULA YES NO NO NAME OF Middle 4. DATE Month Day Year DECEASED (Type of print) DEATH 19-5 5. SEX 6 COLOR OR RACE 7. MARRIED TO NEVER MARRIED TO B DATE OF BIRTH 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys DIVORCED IT WIDOWED [7] 10a. USUAL OCCUPATION (G ve kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, eyen if retired) 12 CITIZEN OF WHAT COUNTRY ROFESSIONAL USSIA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ENOUN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address LD WHRI 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (6)  $U/G \times$ **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** couse (a), stating the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 /WAS AUTOPSY PERFORMEDA 1101111111 YES TO NO P 20g ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of ulivry in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (Slote) factory, street, office bldg, etc.) Hour a.m. Not while While of work at work D. m. 21. I certify that I attended the deceased from, 19\_\_\_\_\_,that I last saw the deceased alive on and that death accurred at M. from the causes and an the date stated above ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL PHYSICIAN'S NAME (Type) BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City town, or county) (State) REMOVAL (Specify) DURIN CON **EUNERAL DIRECTOR'S SIGNATURE** 240 REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE Clothur & Miser's

DATEEB 3

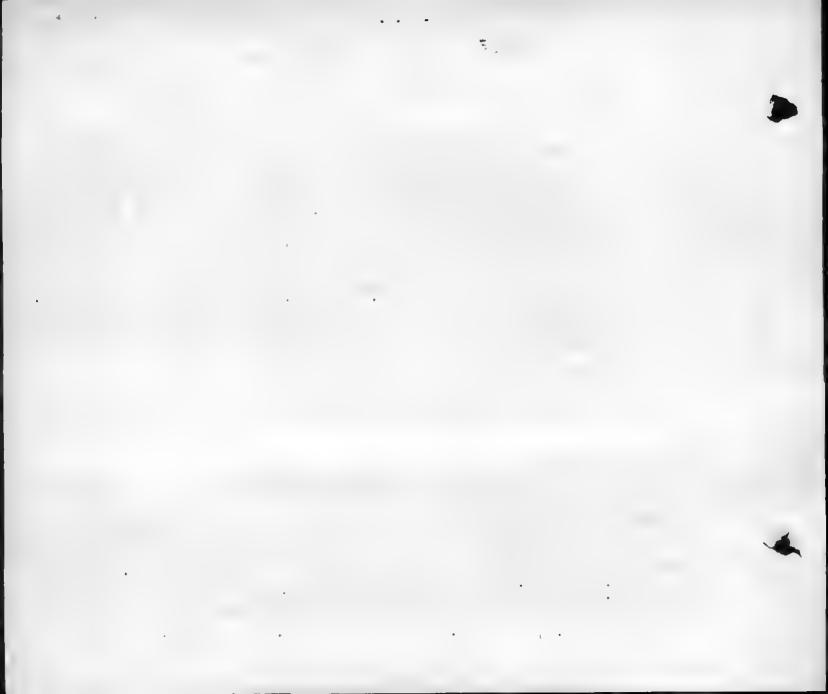
72 house FUNERAL 2 VS A15 (4) 15M 10/57

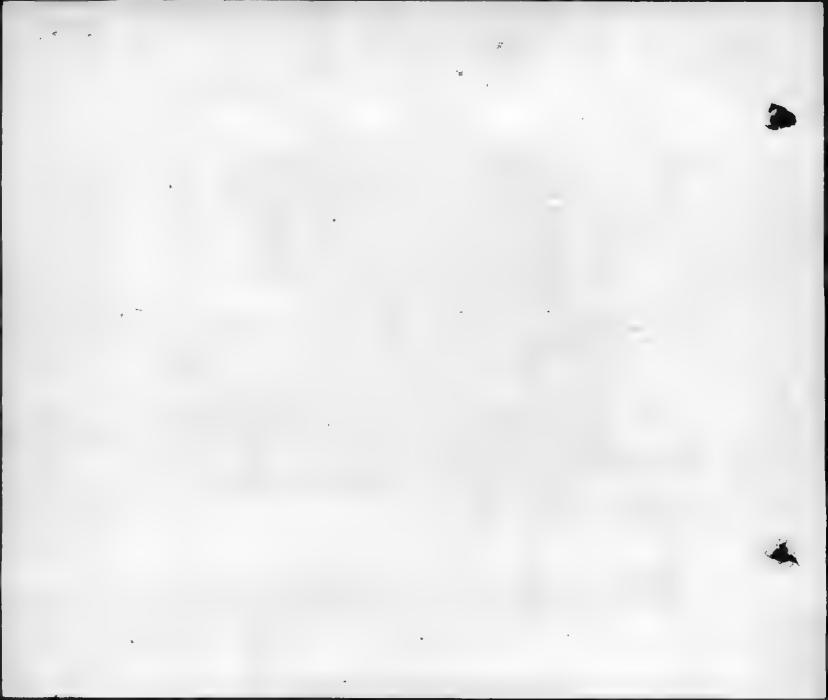


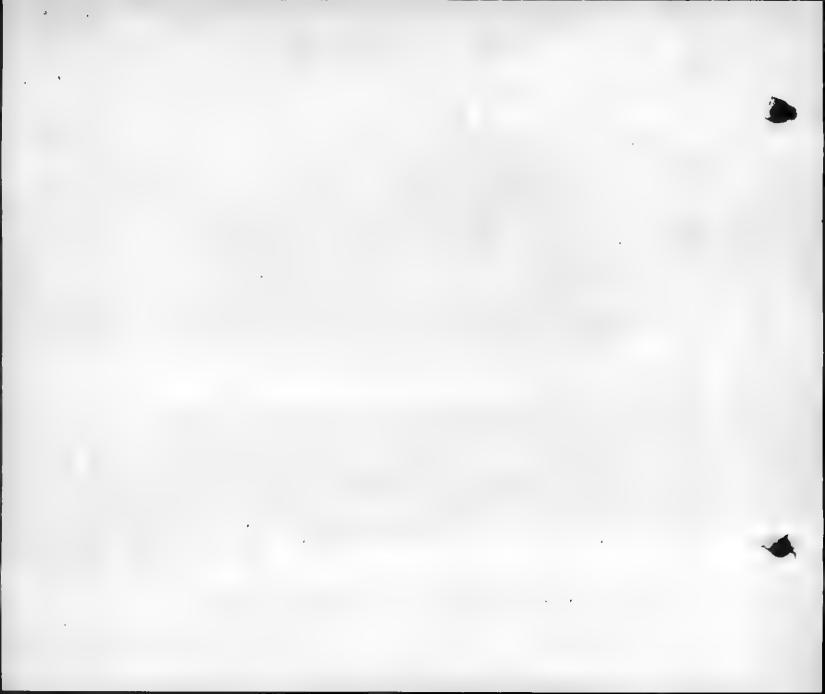
I.	0017				Keg. Dist. No.
	PLACE OF DEATH Wicomico	MARYLAND	2 USUAL RESIDENCE (WE o. STATE Mary	and b county	Wicomico
	b. CITY OR YOWN (If outside corporate timits, write RURAL and give profest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (IF a	outside corporate limits, write RU	RAL and give nearest town)
	d NAME OF HOSP TAL (If not in hospital, give street or institution pen Gen Hospi	address) tal	d. STREET ADDRESS Stati	lon St	e IS RESIDENCE ON A FARM? YES   NO
ĺ	3. NAME OF DECEASED (Type or print) LOTTIE	Muddle MURRAY	SHORES	4. DATE Month OF JAN	
	5. SEX 6. COLOR OR RACE 7 MARR Female White WIDOW		June 4, 189	Lost highland	Months 28s Haurs Min
	Osual Occupation (Give kind of work done 10b. during most of working life, even if cetired) Employee (Shirt Factor)			or foreign country) Maryland	US A
	13. FATHER'S NAME		14. MOTHER'S MAIDEN N	IAME	<del></del>
-	Albert Smith		Mary Hi]	Llman	
	15 WAS DECEASEDEVER IN U. S. ARMED FORCES? (If yes, give wor or dated of service)	SOCIAL SECURITY NO.		Shotes (Husbar Maryland	id)Station St.
	PART I. DEATH Enter only one couse per lie  PART I. DEATH WAS CAUSED BY  IMMEDIATE CAUSE (a)  Conditions, if ony, which gove rise to immediate couse (a), stoting the under-  lying couse lost.  [c]	arcinon	Carcino de la	na of Lin Freart	INTERVAL BETWEEN ONSET AND DEATH
2	PART II. OTHER SIGNIFICANT CONDITIONS OF THE PART III. OTHER SIGNIFICANT CONDITIONS OF THE	CONTRIBUTING TO DEATH BUT			N IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO 12
	20b. DESC CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	THE TION HOOK! OCCURRE	s. (Crief holdre of injury in i	off for roof a or flem to.)	
	Hour a.m. White	NJURY OCCURRED 20e. PL/ Not while at work	ACE OF INJURY (Home, form tory, street, office bldg., etc.	20f. (City or town)	(County) (State
	21. I certify that I attended the decease alive on 2 2		occurred at 3: 9,51	M, fram the causes an	that I last saw the deceased on the date stated abay
	Dr. David N. G.	ilmore	M.O. Sale	buy ted	Jan. /195
	PHYSICIAN'S Dr. Wilbur Ell		Medical Cer	nter, Salisbu	ry, Maryland
	270. BURIAL CREMATION, 226 DATE THEREOF REMOVAL (Specify) BURIAL Jan. 5, 1958	St. Johns		22d. LOCATION (City, lown, or Fruitland,	
	3. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC*	BY REGISTRAR 246 REGIST	RAR'S SIGNATURE
	HOLLOWAY & COMPANY S.	ATTSRURY MAR	VIAND OUT	4 11 12	

and campletely filled in by may be retained by the pospitor of attentions proposed by the attending physician and cample by EVERAL DIRECT. After this certificate has been signed by the attending physician and cample page 3 should be delicated for use as the buriol-transit permit. Then please remove carbon-pageth, the registrar prior to buriol, cremotion, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECT
Poge 3 should be delo VS A15 (4) 15M 10/57









ol director, e filed with 1308

CERTIFICATE OF DEATH

Reg. Dist. No

1. PLACE OF DEATH o. COUNTY W1COM1CO MARY	2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Waryland b. COUNTY WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Salisbury	X Salisbury
or institution D.O.A. Pen Gen Hospit	R.D.# 1 e is residence on a farm?
3 NAME OF First Middle DECEASED (Type or print) ELIZABETH MARI	IE THOMPSON DEATH JAN. 1st 1959
5. SEX Female   6. COLOR OR RACE   7 MARRIED   NEVER MARRIED   WIDOWED   DIVORCE	lost birthday) Months Dave House Star
USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS Of during most of working tie, even if retired) Employee (Secretary) Chicken Ha	DE INDUSTRY 11 RIPTHPLACE State or freign country
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Becker	Marie Reese
15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. [14 year, given wor or dates of service]	Wrs. Ida M. Nichols (Daughter) R.D.# 3 Carey Ave. Salisbury, Maryland
IB. CAUSE OF DEATH [Enter only one couse per line for (of, fb), and (c)  PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)  14 20 / DUE TO	nary acclusion Sinterval Between ONSET and DEATH
Conditions, if ony, which gove rise to immediate couse (a), stating the <u>under-lying couse last.</u> (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEA	ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED?
	CCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.)
(IF EITHER, NOTIFY MEDICAL EXAMINER)	CONNED. ILINE HOUSE OF INJURY IN PORT OF FOR IT OF HEM ID ]
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of work	20e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I attended the deceased from olive on 1957 and that  ACTUAL SIGNATURE	deoth occurred of
PHYSICIAN'S Dr. Philip A.Insley	Main St. Salisbury, Maryland
PENERVAL Speciful - P	etery or crematory 20d. location (City. town. or county) (Stote)  Memorial Park Salisbury, Maryland
20. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALTSBURY	MARYLAND DATE JAN 5 39 C - P TIME

TO HOLITIEL OR ATTENBILL MAY ICTAN: The law requires that the death certificate be executed within 24 hours of may be retained by haspital ar attending physician.

O FUNERAL DIRECTAL After this certificate has been signed by the attending physician and campletely filled in by page 3 shauld be defached far use as the burial-transit permit. Then please remays-estban papers. Pages 1 and 2 the register prior to burial, cremation, or remayal, and in any event within 72 mayors after death. may be retained by VS A15 (4) 15M 10/57

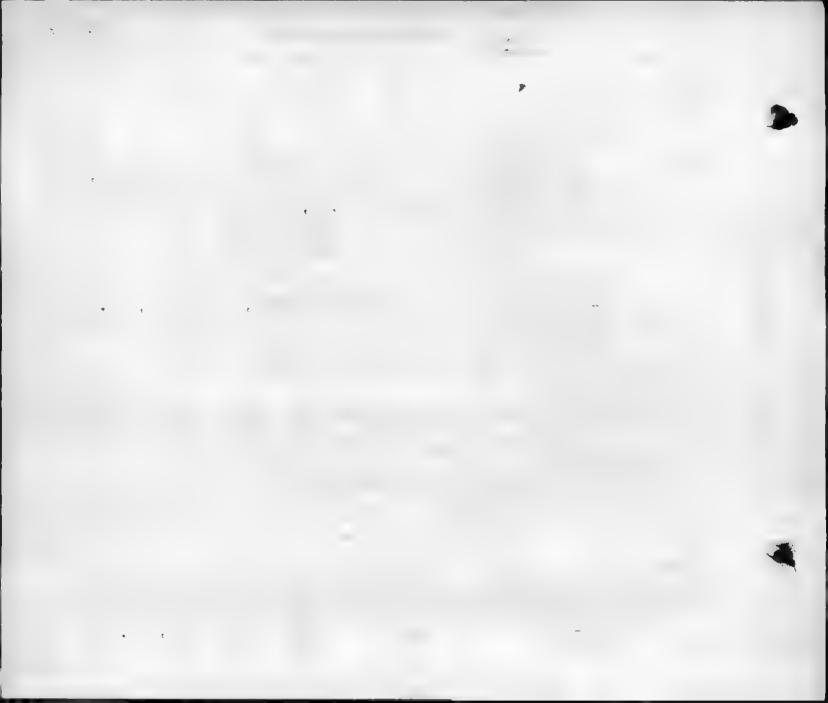
0 VS A1S (4) ISM 9/5

HOSPITAL

death. Page

death certificate

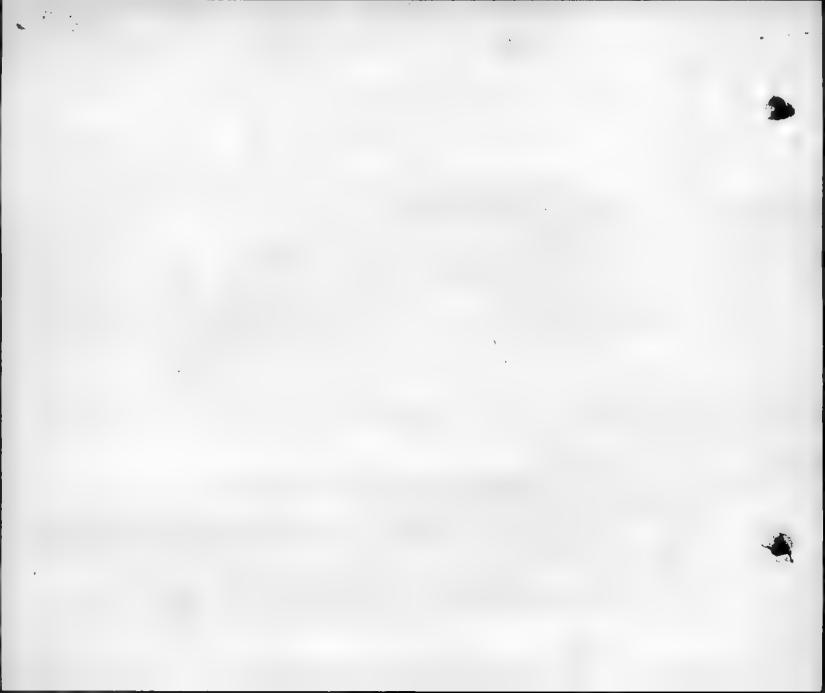
requires that the



Rea. Dist. No -2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission b COUNTY Baltimore City c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e IS RES DENC ON A FARM? YES NO T 1059 January 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS loss-birthdoy) Months Days 12 CITIZEN OF WHAT COUNTRY U.S.A. Address Deer's Head State Hospital Records, Salisbury, Md. ONSET AND DEATH 9 hr. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19, WAS AUTOPS PERFORMED? YES 🔲 NO F 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) (County) (State) 21. I certify that I attended the deceased from April 1 ... 19.52, to Jan. 6 ... 19.59, that I last saw the deceased ADDRESS (Street, city or town, state) DATE SIGNED Mo Deer's Head State Hospital PHYSICIAN'S V. Juerman. M. D. Salisbury, Maryland NAME (Type 220 BURIAL, CREMATION, 226 DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d LOCATION (City town, or county) (State) REMOVAL (Specify) 23 FUNERAL DIRECTOR'S SIGNATURE 24b REGISTRAR'S SIGNATURE

VS A15 (4) 15M 10/57





. 01324

2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) c. CITY QR TOWN (If outside carporate limits, write RURA), and give negrest town) e, IS RESIDENCE YES NO T Year Day 195 IF UNDER I YEAR IF UNDER 24 HR Months Doys 12. CITIZEN OF WHAT COUNTRY? S A . Address ANNE. ND INTERVAL BETWEEN ONSET AND DEATH PART II. OTHER SIGNIFICANT, CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES TI NOT (County) (Stote) 19 1, that I lost sow the deceased and that death occurred of LO ALM, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED, 22d LOCATION (City lown or county) (Stote) BUF IAL John Wesley Princess Anne Maryland 23 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE JAN 2 1 '59 WILLIAM H. JAMES BR, PRINCESS ANNE, MD

0 VS A15 (4) 15M 10/57



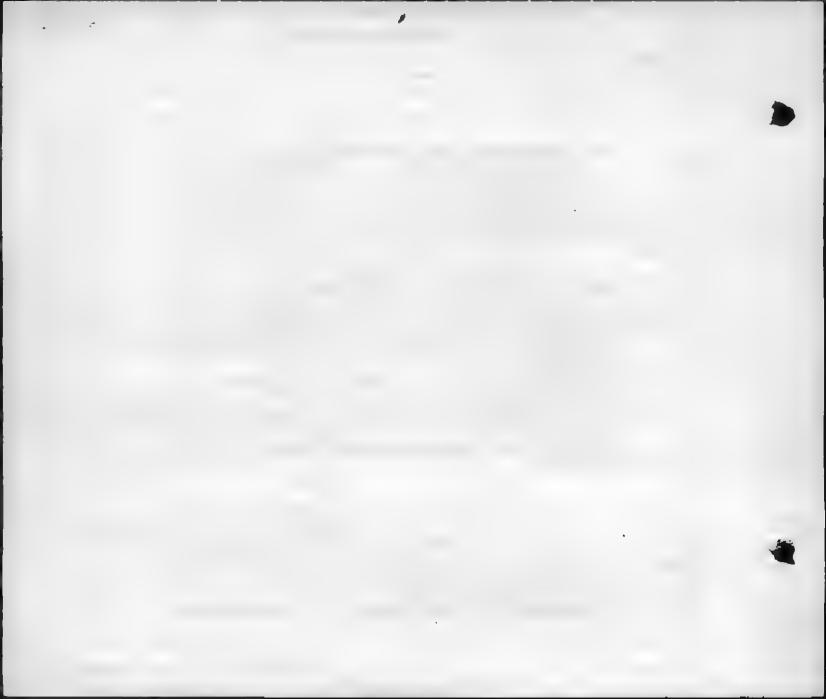
**CERTIFICATE OF DEATH** 

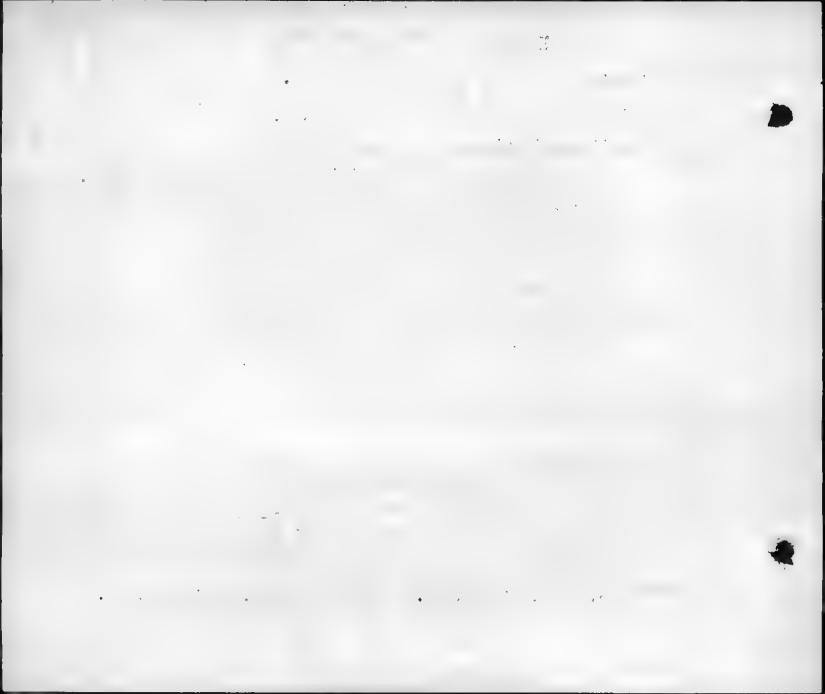
Reg. Dist. No.

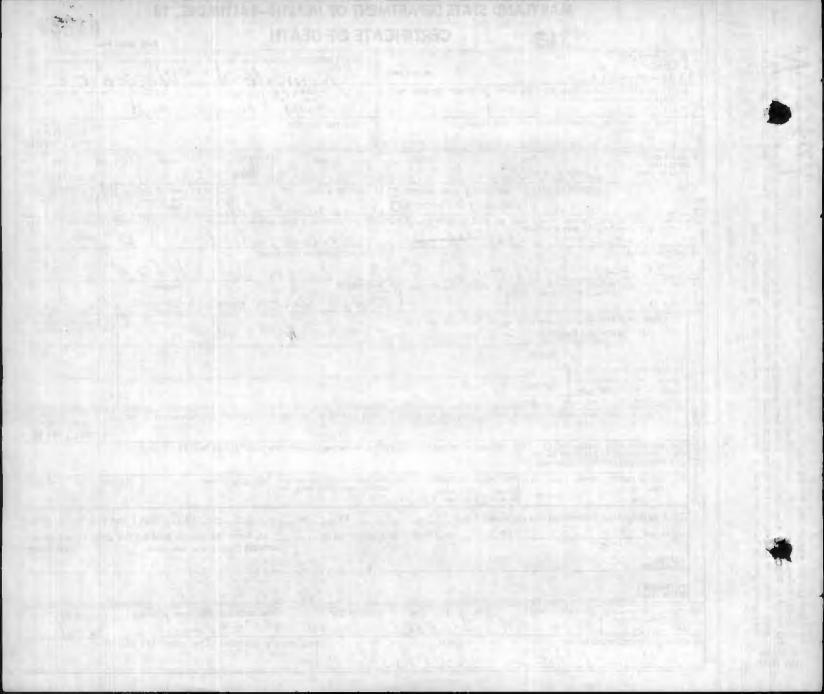
		Reg. Dist, No.	
1		PLACE OF DEATH  COUNTY VICONICO  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  b. COUNTY Som ERSET  MARYLAND	
	P	CCITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY ON TOWN (If autside carporate limits, write RURAL and give nearest town)  RURAL and give petrent town)  TAR PTOWN  24RS  DEAL  SARND  19X-2	
3	1	NAME OF HOSPITAL (IF not in haspital, give street address)  OR INSTITUTION  ON A FARM  YES   NO	?
		NAME OF DECEASED MINNE Middle WEBSTER 1. DATE Month Day Year OF DEATH JAN 16 195	9
	5.5	EX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH  EMALE WHOWED DIVORCED 7EB 21-1878 9. AGE (In years   IF UNDER 1 YEAR IF UNDER 24 H)  Months Days Haurs Min	
	100	BSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  Avring most of working life, even if retired)  TOUSEHOLD DYTIES HOUSEHOLD MARYLAND	TRY?
	13.	MESLEY ABBOTT VIRGINIA JONES	
	15.  Yes	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Address  THOMAS WEBSTER - DEAL ISLAND M	10
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  CAR CINITINA - Decending California (California)  ONSET AND DEATH  OUT OF CAUSE (CALIFORNIA)	Ĥ
		/53,2 DUE TO	
		gove rise to immediate case (a), stating the <u>under-lying cause last.</u> (b)  DUE TO  (c)  (c)	
1	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS PERFORMED?  YES   NO	
	CERTIFI	20s. ACCIDENT WAS UNDERLYING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port 11 of item 18.)	
	MEDICAL	29c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Have a.m.  p. m.  19 While Not while at work at wore work at	rle)
		21. I certify that I attended the deceased from Machine, 1957, to John 16, 1959, that I last saw the deceased alive an John 1959, and that death occurred at M. from the causes and an the date stated about	
		ACTUAL SIGNATURE / SKikhing au M.D. Skarpton Mil (1) 1/7/59	
Ĵ		PHYSICIAN'S H.S. KUHIMAY	
	220	RURIAL, CREMATION, 226. DATE THEREOF 27c. NAME OF CEMETERY OF CREMETERY OF CREMETER	
1	23.	FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS  ADDRESS  DATE  AND 2 3 39  24b. REGISTRAR'S SIGNATURE  DATE  AND 2 3 39	

TO FUNERAL DIRECT. A. After this certificate has been signed by the ottending physician and completely filled in by the production, page 3 should be defrached far use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filled with the registror prior to burial, crematian, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. Page 4







VS A15 (4) 15M 10/57

#	
	1. PLACE o. COU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CER

111299

	ATE OF DEATH	1		Reg. Di	st. No		
	2. USUAL RESIDENCE (WH	ere deceose	ed lived. If instituti	on: Resider	nce befo	re admiss	ion)
RYLAND	o. STATE Maryl		b. COUNTY	-	rles		
AY IN 1b	c. CITY OR TOWN (If o		orate limits, write R				1) (
ays	Pomonkey			TTV	_ 8	1	
-	d. STREET ADDRESS			200		e. IS RES	IDENCE
		ndian	Head P.	).			FARM?
die	Lost	4. DATE	Mon	th	Do	y ,	Yeor
ard	Yates	DEATH	January		5		19 59
RRIED 🗌	B. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER		-	
CED 🗌	August 188	0	78 yrs.	Months	Days	Hours	Min.
OR INDU			country)	12. CI	IZEN C	F WHAT	COUNTR
· nut	Port Toba	000	Marylad		TT	S.A.	
1000	14. MOTHER'S MAIDEN N		rat y rau			D, A.	
		12	124				
NO. 17. II	NFORMANT	01	VL				
_			Add				
D	eer's Head St	ate H	ospital F	lecord	is,S	alis	bury.
(c).]					INT	ERVAL BE	TWEEN
f pro	state with me	tasta	ses		10.11	SET AND	DENTI
y due	NOT RELATED TO THE TERMING to cerebral  D. (Enter noture of injury in F	throm	bosis	'EN IN PAR	T 1(a) 1	9. WAS PERFO YES T	AUTOPSY RMED? NO
OCCURRED	to cerebral	throm	bosis		T I(a)   I	PERFO	RMED?
OCCURRED 20s. PU	to cerebral  D. (Enter noture of injury in F  ACE OF INJURY (Home, form, tory, street, office bldg., etc.)	throm	bosis of (I of item 18.) y or town)	{(	County)	YES	RMED? NO (Stole)
20e. PLV foc	to cerebral  D. (Enter noture of injury in F  ACE OF INJURY (Home, form, tory, street, office bidg., etc., 19 57, ta	throm	bosis of (1 of item 18.) y or town) 5, 19.59	(fat 1	County)	YES W	(Stole)
20e. PU foc	to cerebral D. (Enter noture of injury in F ACE OF INJURY (Home, form, street, office bldg., etc.  19 57, ta accurred at 1:40	throm ont for Port 20f. (Cin	bosis of (1 of item 18.) y or town) 5, 19.59	,that I	County)	YES Wither the state	(Stole)
20e. PU	to cerebral D. (Enter noture of injury in F ACE OF INJURY (Home, form, street, office bldg., etc.  19 57, ta accurred at 1:40	Jana AM, from	bosis If (I of item 18.)  y or lown)  5, 19 59  m the Causes a  itreet, city or town,	,that I and an ti	County)	YES Wither the state	(Stole)
20e. PU	to cerebral D. (Enter noture of injury in F ACE OF INJURY (Home, form, street, office bldg., etc.  19 57, ta accurred at 1:40	Jana AM, from	bosis If (I of item 18.)  y or lown)  5, 19 59  m the Causes a  itreet, city or town,	,that I and an ti	County)	YES Wither the state	(Stole)
20e. PU	to cerebral  D. (Enter noture of injury in F  ACE OF INJURY (Home, form, street, office bldg., etc.  19.57, ta  accoursed at 1:40  M.D. Deer's Her	Jana AMA, frai ADDRESS (S	bosis of the 18.)  y or lawn)  5, 19.59  m the causes a direct, city or town. ate Hospi	,that I and an ti	County)	YES Wither the state	(Stole)
y due OCCURRED 20%. PU foc	to cerebral  D. (Enter noture of injury in F  ACE OF INJURY (Home, form tory, street, office bldg., etc.  19.57, ta  accurred at 1:40  M.D. Deer's Her	Jana Marris Marr	bosis  If If of item 18.)  y or lown)  5, 19 59  In the causes a direct, city or town, ate Hospi	,that I and an the stote)	County)	ves withe	(Stole) deceased abavets signes
y due OCCURRED 20%. PU foc	to cerebral  D. (Enter noture of injury in F  ACE OF INJURY (Home, form, street, office bldg., etc.  19.57, ta  accoursed at 1:40  M.D. Deer's Her	Jana Marris Marr	bosis of the 18.)  y or lawn)  5, 19.59  m the causes a direct, city or town. ate Hospi	,that I and an the stote)	County)	YES Wither the state	(Stole)  (Stole)  decease d above ATE SIGNE

	13		CERT	IFIC.	ATE OF DEATH	1		Reg. Dist.		J. O.B.
PLACE OF DEATH	comico		MAR	YLAND	2. USUAL RESIDENCE (WHO o. STATE Mary)		d lived. If institution b. COUNTY	on: Residence	before adm	ission)
b. CITY OR TOWN (III RURAL ond give ne Salisbi	f outside corporate limitarest town)	its, write	c. LENGTH OF STAT		c. city or town (if a		rate limits, write l			wn)
OR INSTITUTION	Head State				d. STREET ADDRESS  R.F.D. I	ndian	Head P.	0.	ON	ESIDENCE A FARM?
NAME OF DECEASED (Type or print)	Fii Jo	ohn	Middle Edwa		Lost Yates	4. DATE OF DEATH	January	nth	Doy 5	Yeor 19 59
Male	6. COLOR OR RACE	7. MARRIE			B. DATE OF BIRTH August 188	0	9. AGE (In years last birthdoy) 78 yrs.	Months D	EAR IF UN	DER 24 HRS
during most of work  Retir	ing life, even if refired	done 10b. K	U.SG	OR INDU	STRY 11, BIRTHPLACE (Sloke Port Toba	or foreign co	ountry)	12. CITIZI	U.S.A	
3. FATHER'S NAME - 1 2 A 2 K					14. MOTHER'S MAIDEN N		DK.		01011	
(es, ng, or unknown)	R IN U. S. ARMED FOR		NONE C		nformant eer's Head St	ate Ho	Add		Seli	ahunv
		Car		-]	state with me				INTERVAL ONSET A	BETWEEN
		1								
couse (o), stoting a lying couse lost.  PART II. OTH  200. ACCIDENT WA. OR CONTRIBUTING (IF EITHER, NOTIFY I	Left resi	Idual	hemiplegy	due	NOT RELATED TO THE TERMII  to cerebral  D. (Enter noture of injury in F	thromb	osis	/EN IN PART I	PERI	S AUTOPSY ORMED?
lying couse lost.	Left rests underlying []  I cause of death medical examiner)	Edual.  206. DESCI	hemiplegy RIBE HOW INJURY OF	due OCCURRE	to cerebral	thromi	11 of item 18.)	/EN IN PART I	YES [	ORMED?
PARY II. OTH  20a. ACCIDENT WA. OR CONTRIBUTING (IF EITHER, NOTIFY I  20c. TIME OF INJURY Hour o. m. p. m.	Left rest Sunderlying and Cause of Death Medical examiner) Month, Day, Year 19 at 1 attended the	or 20d. IN. While of work decease, 19.5	hemiplegy RIBE HOW INJURY OF  DURY OCCURRED  Not white  of work  d from Nov.	due CCURRE 20e. PL for	D. (Enter noture of injury in FACE OF INJURY (Home, form, ctory, street, office bldg., etc.	Jan Sam Sta	or town)  or town)  the causes of the causes of the causes of the the cause of the	(Cou	YES [	(Stole

